			Cei	rtificate o	f Death		Re	g. No. 9 9	4!501		
Decedent's Nama (First, Middla, I	ast)						2. Data of Death Month		3. Tima of Death		
ELEANOR MERR	ICK						DECEMBE		99 03:40 AM		
4a Facility Nama (If not institution, g	iva street and number	r)			4b. City, To	wn, or L	ocation of Death	4c. County of			
GREATER BALTIM	ORE MEDICA	L CENT	ER		TOW	SON		BALTIM	ORE		
	Sax 7. A	iga (In yrs. las		If Under 1 Ye Months Day		24 Hrs. Min.	8. Data of Birth (Month, Day,	Year) 9	Birthplace (State or Foreig Country)		
219. 32. 9323	1LJM 2KJF	61	Yrs.				09.25.	38	mo		
Usual Rasidance of Decedant 10a, Stata 10b, County		100 City	Tour or La	eation					404 4414 00 4 1 1		
,	10		Town or Lo						10d. tnside City Limit		
mo N	А	BALTI	MORE	٤					TE TAS ZEIN		
10e. Street and Number				10f. Zip Code	•		10	g. Citizen of Who	at Country?		
1124 ELBANK AVE	NUE			212	39			u	SA .		
11. Marital Status	12. Was Decedan Armed Forcas	t Evar in U,S.	13.	Was Decedent of If Yas, specify C	f Hispanic Or	igin? (Sp	ecify Yas or No- Rican, atc.)		Amarican Indian, Whita, atc.		
1 Nevar Married 2 Married				1 Yas 2 I			,	0*			
3 ☐ Widowed 4 ☐ Divorced	Yaar or Datas	:		10100	о ороспу.			эрвспу.	Specify: BLACK		
15. Decedant's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Busines (Give kind of work done during most of working									ness/Industry		
Elementary/Secondary (0-12)	College (1-40)		lifa. I	DO NOT use ref	ired)						
2 TH GRADE	NA	P	DMIN	JISTRATI					e mo		
17. Fathar's Nama (First, Middla, La.	st)				18. Moth	er's Nem	e (First, Middle, M.	aidan Sumama)			
PAUL WHETSTONE					MAGA	RET	ATIKIN	S			
19a. tnformant's Name/Ralationship	(Type, Print)		19b. Maitir	ng Address (Stre	et and Numb	er or Rui	al Route Number,	City or Town, St.	ata, Zip Code)		
SHAUN MERRICK	DAUGHT	ER '	7200 (CHALKSTI	NE D	R. 1	BAUTO. MI	0. 21208	THE PARTY OF THE P		
20e. Mathed of Disposition		0.00	oe of Dispo	sition (Nama of matory or other)	v/ace)		Data 2	0c. Location - Cit	ty or Town, Stata		
1 ☑ Burial 2 ☐ Cramation 3 4 ☐ Donation 5 ☐ Other (Spec			MEN	IOPIAL	PARK	- 4	-4-00 R	ANDALLST	DKIN MO		
21. Signatura of Funaral Sarvice Lic	ensee		22	Name and Ade	trass of Facili	tv					
101	C 4		4.				FUNERAL				
23a Part1 Enter the dispuse or co	motications that cause	ad the death	Par				BAUD.		Approximata		
23a. Part1. Enter the disease, or co shock, or haar failure. List on	y ona causa on aach	lina.	DO HOL GIL	ar the mode of t	yaig, suon us	carolac	or raspiratory arre-	,	tntarval Batween Onset and Death		
tmmediete Cause (Finel	7.		10		near h	101	heno	a-aha	1 1140-		
disaasa or condition rasulting In death)	a	TRAIC	CHIN	TAL ((ED	TIC	peone	066/116	6 4H025.		
	-,-	Due to (or a		13					11.11.		
	b	7-1-1		05121	V				4 His.		
Sequentially list conditions, if any, leading to immediate	-	Dua to (or a			E				418 Hos		
cause. Entar Undarlying Cause (Diseese or injury	· 13	Chicio	MIC	20/1	10	01			10 1103		
that initieted events rasulting in death) Last		Dua to (or e	s a conseq	uence of):							

Physician /Medical Physician/Medical Examiner To the Hospital or Attending Physician: The lew requires thet the death cartificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Director

Funeral

Be Completed by

2

Part II. Other

Hospitel:

24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed?

1 Yas 2 No 26. Place of Death (Check only one)

1 ☐ Yas 2 ☐ No

25. Was casa rafarred to medicat axaminar? 1 Yas 2 No 27. Manner of Death 1 Natural 5 Panding invastigation

6 Could not be determined

1 Inpatiant 28a. Data of tnjury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Routa Number, City or Town, Stata)

28d. Describe how Injury occurred

29a. Cartifier (Check only one)

2 Accident

3 Suicida

4 Homicide

1 Certifying Phyalotan: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner as stated.

2 Medicat Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifiar

29c. License number

29d. Data signed (Month, Day, Year) 12.30-99

30. Nema and addrass of person who completed cause of death (Item 23a) (Type, Print)

Belain RO 2112 REICHMAN MO WAYNE

State Registrar

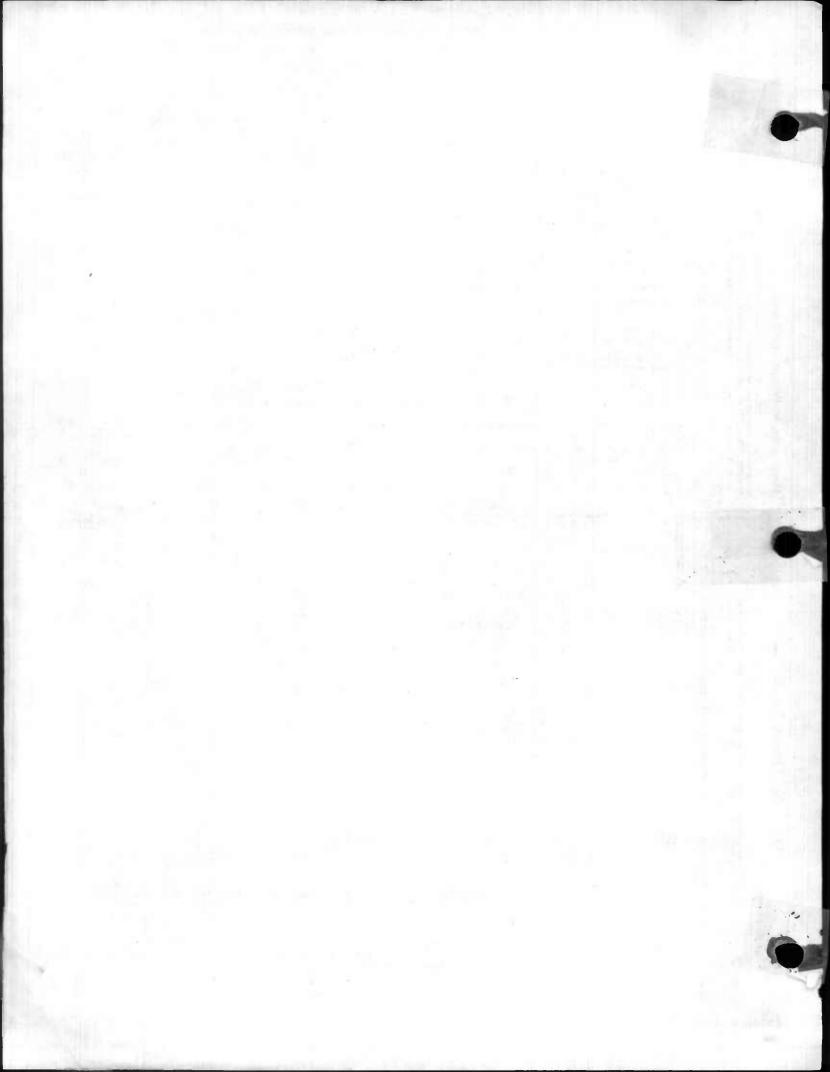
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Medical Certification: To

32. Registrer Signatura

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate				Reg. No.	9 1	1502		
Physician	Decedent's Name (First, Middle, Eva Beverly Ma			2. Deta of De Month December	D. W.		3. Time of Death					
/Medical Examiner	4a Facility Name (If not institution,	4	b. City, Town, or L			nty of Deeth						
	Columbia Group Home		Columbia Howard									
Funeral Director	5. Social Security Number 214 72 6921 Usual Residence of Decedent	1 M 2 F 65	(In yrs. last birthday, Yrs.	Months	1 Year Days	If Under 24 Hrs. Hours Min.	8. Dete of Birt (Month, Da March 6,	1934	Cou	plece (State or Foreign nore, Maryland		
ahow	10a. State 10b. County		10c. City, Town or L.	ocation						10d. Inside City Limits		
1 28a-f show hothed as	Maryland Baltimore		Baltimore Co							1 Yes 2 No		
iter death with the Maryland r fleme 23s or 28e-f show niner must be hottled at Funeral Director	10e. Street and Number 4304 Necker: Avenue			10f. Zip	6			USA	of What Cou	ntry?		
ours after decrease, or frame	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1		Was Deced If Yes, speci 1 Yes		spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		lace - Ameri Bleck, White, Cify: Whit	etc.		
Higher within 72 hours after Higher than "netural", or fee and, the Medical Exempts and, Completed by Fu	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	16a. Decs (Give iile. +) Assemb]		k done d e retired	done during most of working retired)			16b. Kind of Business/Industry				
avent, the	17. Father's Name (First, Middle, La	•				18. Mother's Nam		Maiden Sum	faiden Sumame)			
th and Mental Hyg 7 Is marked othe traumatic avant, To Be C	Charles Walter Mauer						ichael		Tour Onto The Ondah			
th and	19a. Informant's Name/Relationship Helen Mauerhan (Sta	p mother)						yland 21236				
f of Health	20a. Method of Disposition		20b. Place of Disp	osition (Nam	ne of		Dete	20c. Locatio		own, Stete		
ant: H	X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Gardens of		-		99	Baltimor	altimore, Maryland			
Department of F Important: If Na any Injury or of pnea.	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Lassahn Funeral Home, Inc. 7401 Belair Road Baltimore, maryland 21236											
hysician /Medical examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	Due to (or as a consequence of): Due to (or as a consequence of):							12 YEARS		
shending physician ifter use as the buris claryMedical E	that initiated events resulting in death) Last	C. Due to (or as a consequence of): d.										
signed by the attending d be detached for use d by Physician/W										bacco use contribute to the cause of death'		
has been ps 2 shoul mpleted					24a. Wes ar			utopsy 24b. Wera autopsy findings available prior to completion of cause of deeth?				
	25. Was case referred to medical	1				26. Place of Dea	th (Check only o		1	Yes 2 No		
this certifinal director	examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Outpatie	nt 3 DO	A Oth	nutr	ome 5 Aesi		Other (Speci	ity)		
	27. Manner of Deeth 1. Natural 5 Pending 2 Accident rivestigat		y Year) 28b. Time (M 28	8c. Injun Worl	rat c? Yes 2 □ No	28d. Describe	cribe how injury occurred				
hours after death. Imparal Director: After it ity filled in by the funeral cal Certification;	3 Suicide 6 Could no determine	building, etc					City or To	wn, Stata)		ral Route Number,		
E STA	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of mminer: On the basis of and manner sta	examination and/or in	th occurred anvestigation,	in my op	e, data and place pinion, death occu	, and dua to the rred at tha tima,	causa(s) and data and plac	manner as a ce, and dua	stated. to the cause(s)		
within 7 To the comple	29b. Signature and title of certifier			29c.	. License	number		29d. Date sig	ned (Month	, Dey, Year)		
1	Deur de der de 30. Name and address of person wh	littling of completed cause of the	m.b.	Dainel		29888				TIETH, 1999		
4		ICHT LING	M.D. 2	KNOW	N	Callen	BIAN	1D 21	045			
State	31. Date filed (Month, Day, Year)		r's Signature									

DHMH 16 Rev 6/95

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99-7632-510 B.K.S RONALD MIDA		State of	Marylan	d / Dena	artmen	of	K. Assure A Health and N	Aental Hy		gible.	1503	
Physician	Decedent's Nama (First, Middle, Lest) Ronald C Nida								Peg. No. Day 19, 19	Year 999	3. Time of Death	
/Medical Examiner	A F Wh All which at the state of the A fine and the state of the State								Location of Death 4c. County of Death			
Funeral Director	5. Social Security Number 6. unknown		7. Age (In yrs. I 48	last birthday) Yrs.	If Under Months	1 Yaar Days	If Under 24 Hrs.	8. Data of Birth (Month, Day, Year) 9. Birth			othplace (State or Foreig country) ryland	
with the Maryland a or 289-f show the notified at Director	Usuel Residence of Decedent 10a. Stata 10b. County Maryland Baltimon	re		y, Town or Lo	ocation						10d. Inside City Limits	
with the Ma a or 28a-f a be notified Director									10g. Citizen o			
er desth Neme 23 Der mas	478 S. Bentalou 11. Marital Status 1□Never Married 2□ Married	Armed For	12. Was Decedent Ever in U,S. Armed Forces? 1			-	Hispanic Origin? (Spoan, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		d States Race - American Indian, Black, Whita, etc.		
Maryland 21215-0020 d 2 should be filed within 72 hours after and Merchal hybjane. T is marked other than "natural", or in traumetic event, the Medical Examins To Be Completed by Fu	3 Widowed 4 Divorced 15. Decedent's 8 (Specify only highest g Elementary/Secondary (0-12)	16a. Dece	1 ☐ Yas 2 ☐ No Specify: Specify: Wh: 1. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/I									
C BEFF O	12 17. Father's Nama <i>(First, Middle, Las</i> Chester Nida	18. Mother's Nama (First, Middle, Maiden Suma Kathryn Anderson						une)				
	19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 16 Warren Road Essex Maryland 21221										ip Code)	
0 = 5 = 8	20a. Mathod of Disposition 1									20c. Location - City or Town, State Brentwood Maryland		
Baltim permit. Pa Department important any injury once.	21. Signalury of Funanti Service Licenses 22. Name and Address of Facility Loudon Park Fune 3620 Wilkens Ave Baltimore, Maryl										Home	
Physician /Medical	Sar Part Lifter the disease, or cor shock, or heart failura. List ont	mplications that ca y ona cause on as						or raspiratory	errest,	1	Approximata Interval Between Onset and Death	
Examiner	Immediale Cause (Final diseasa or condition resulting in death)	a	011	ras a consec		TTY	LIVER			! !	149	
0, an and rial-transit Examiner	cause. Enter Underlying											
Box 68760 ath certificate be a titlending physician for use as the buttle olan/Medical E	Ceuse (Disease or injury that initiated events resulting in death) Last	c	Due to (or	es e conseq	juence of):							
P.O. ust the da d by the setsched Physic	Part II. Other significant conditions	iven in Part I.		I tobecco use		to the cause of death						
Vital Records, idean: The law requires the certificate has been signe rector, page 2 should be do Be Completed by								24a. Wa	s an autopsy iormed?	1	Were autopsy findings ivailable prior to completion of cause of death?	
//tal R	25. Was case referred to medical						26. Place of Deal		Yes 2□No	1	Yes 2 No	
hyaldi hyaldi his ca ai dine To E	examiner?	Hospital: 1 In	npalient 2 🗆	ER/Outpatier	nt 3 DO	A Ot	ther: 4 Nursing Ho			Other (Spec	aify)	

To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this o completely filled in by the funeral directors.

edical Certification: To

Mas 2□ No 27. Manner of Death 1 DNatural 2 Accident 3 Suicide 4 Homicide

29a. Certifier (Check only one)

6 Could not be detarmined

5 Pending investigation 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28a. Data of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 Yas 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledga, death occurred at tha time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier unie

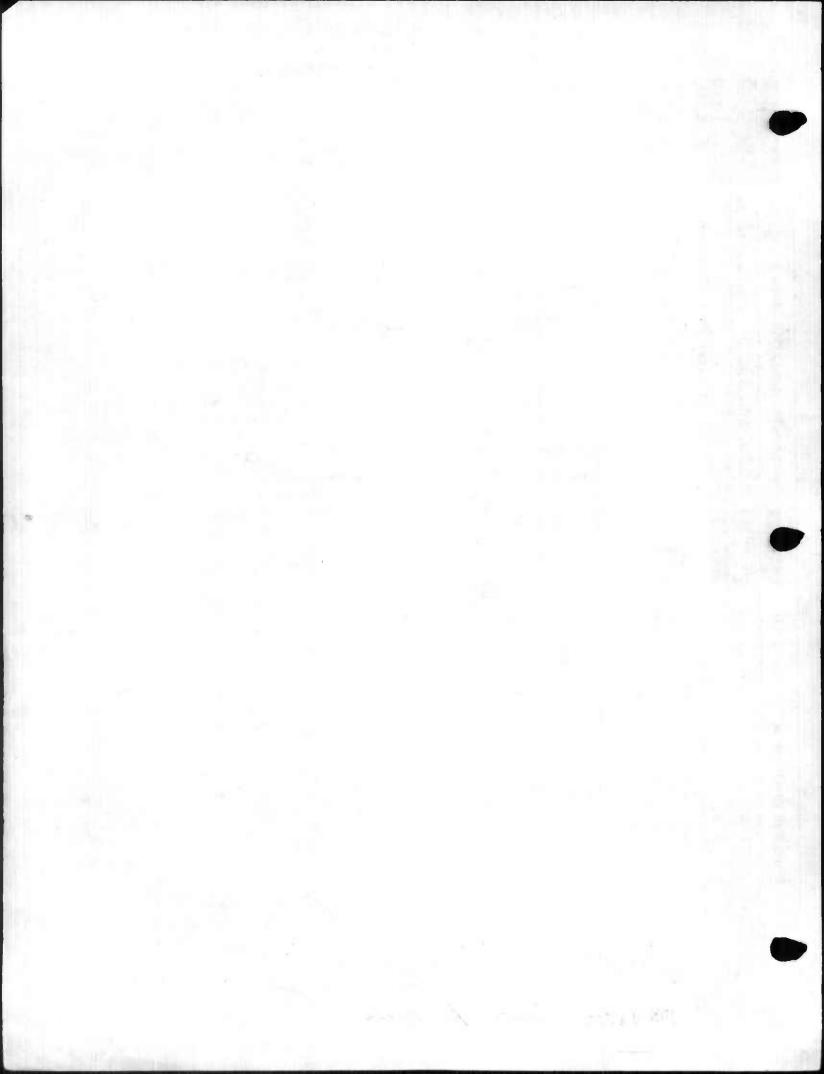
29c. License number O.C.M.E 29d. Date signed (Month, Day, Year) DEC. 21, 1999

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

31. Data filed Manth, Day, Year) 111 Penn Street, Baltimore, Maryland 21201 ONEU 32. Registrar's Signatura

State JAN 042000

ooks!



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month Donald James Nelson Dec. 24, 1999 10:40 AM 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Carroll County General Hospital Westminster Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Nov. 19, 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign Country) 9 Missouri 1**⊠**M 2□ F 70 Yrs. 1929 213-26-5899 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 XNo Carroll Finksburg 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 2258 Baltimore Blvd 21048-1648 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 21 No Specity: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) Painter Self Employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Oscar Nelson Gertrude Smith 19a. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 2258 Baltimore Blvd Finksburg, MD 21048-1648 Norma Nelson, Wife 20b. Pleca of Disposition (Name of cemetery, cremetory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stete t Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 12:29-99 Woodlawn, MD Lorraine Park Cemetery 21. Signeture of Funeral Service-Montage 22. Name end Address of Fecility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne, MD 21227 Approximete Approximete tntervet Between Onset end Deeth Infortion Myscudel 40 min Immediete Ceuse (Finel diseese or condition resulting in death) Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or trijury that initieted events Due to (or es e consequence of): thet initieted events resulting in deeth) Lest Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Afleroschiatic Colonery Vascalas 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Me 11: fors 24e. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Reeldence 6 Other (Specify) Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. injury et Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation

Examiner buriel-transit The law requires that the death certificete be axecuted 68760 Physician/Medical the Box P.O. Records. of Vital Be

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

Funeral

Director

r than "natural", or items 23a or 28a-f ahow

filed within 72 hours efter

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, I'm Manay Injury or other traumatic event.

Physician

/Medical

Examiner

21215-0020

altimore, Maryland

Certification: To s after death. filled in by To the Hospital of within 24 hours all To the Funeral C completely filled edicai

31. Dete filed (Month, Day, Yeer) State Registrar

29b. Signeture end title of cartifier fell 1 Mos, mo

6 Could not be determined

1 Yes 2 No

29d. Date signed (Month, Dey, Yeer) 26

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

Business Confor Dive Reinfording Mo obert L. Moss

28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

32. Registrer's Signeture JAN 0 4 2000

1 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

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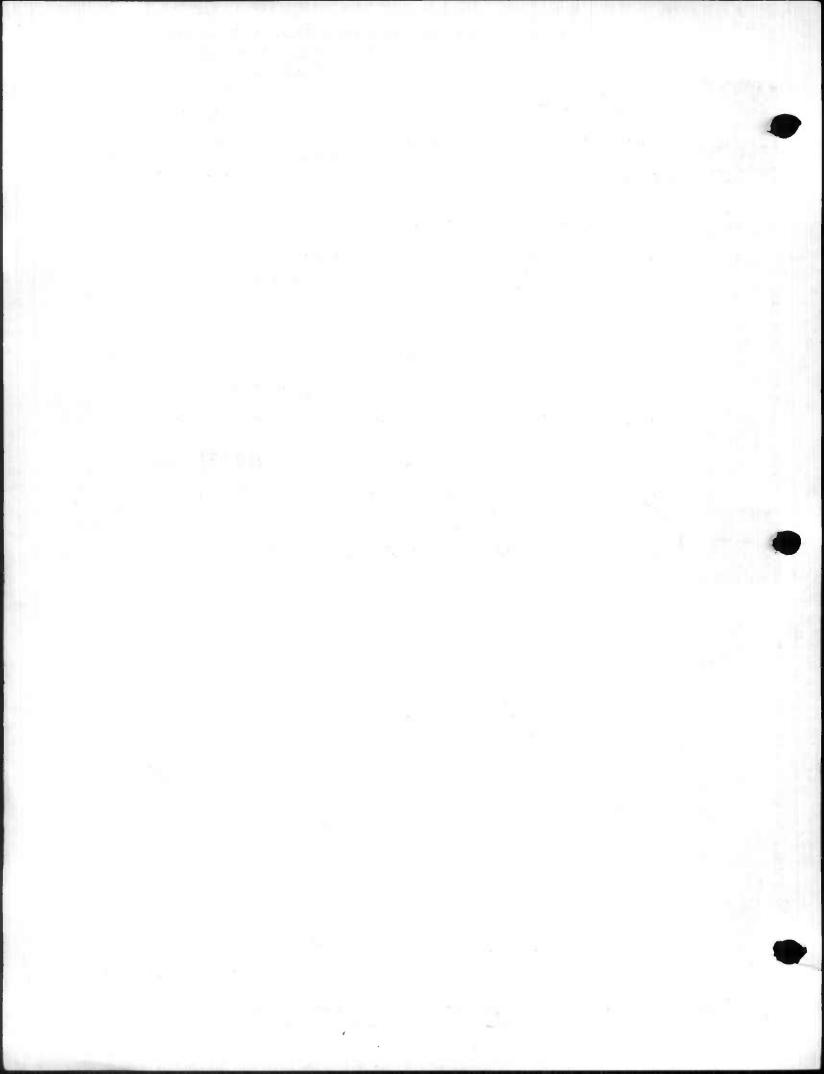
2 Accident

3 Suicide

29a. Certifier

4 - Homicide

(Check only one)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Mollie 12 31 1999 1603 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Yeer Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 J.F Yrs 80 Director 21 1919 105-28-0172 Usual Residence of Deced N.Y. death with the Marylend 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Palm Beach Delray Beach 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14715 Wildflower Lane 33445 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours efter or Department of Heelth end Mentel Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumetic event, the Medical Examinat page. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify Specify: þ 3 Widowed 4 □ Divorced Year or Dates: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Automobile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David Grossman Yetta Moskowitz 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Eileen Cerniglia/daughter 1589 Keswick Place, Annapolis, Md 21401 20a. Method of Disposition 20b. Plece of Disposition (Neme of Date 20c. Location - City or Town, State cemetery, crematory or other place) Gard 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/3/2000 Boynton Beach, FL Eternal Light Memoral 21. Signature Funeral Service Licens 22. Name and Address of Fecility Sterling-Ashton-Schwad Function 736 Edmondson Avenue, Balto, Md. 2122 Approximate Interval Between Onset and Death 23e. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner requires that the death certificate be executed physician end s the buriel-fransit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medicai Bue to (or es a consequenca of usa as 50 signed by the eld be detached for Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1X Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed monon ata has page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 28. Plece of Death (Check only one) Hospital: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending after death. 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) completaly filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and menner stated. 29a. Certifie Medical within 2 \$ 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0

30

State State Registrar

31. Dete filed (Month, Day, Year)

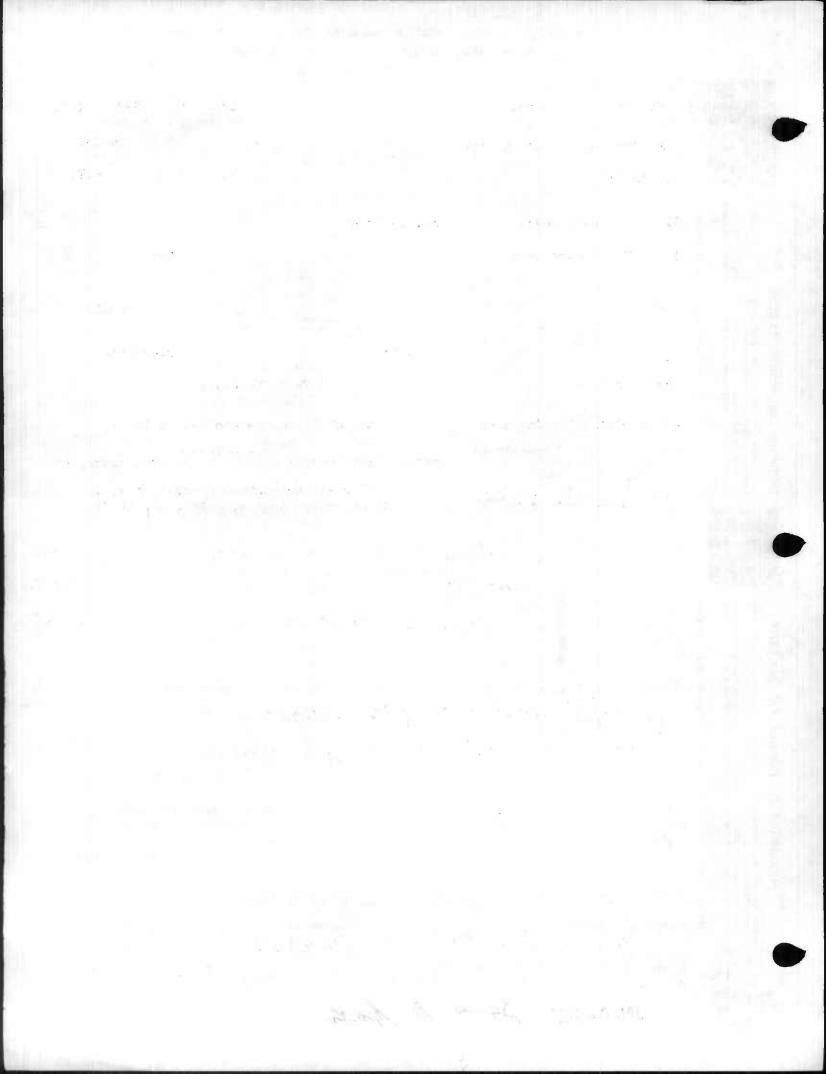
JAN 0 4 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



mest Dr. Annapolis MD 21401

12000



Please Type or Print in Black Indelibie Ink. Assure Ali Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Detect Postb.

			•	Certific	ate of L	Death	R	eg. No.	3 4	1200		
		1. Decedent's Name (First, Middle, Last)	0 1				2. Date of Dear Month		Year 3.	. Time of Death		
	sician edical	Kitherine	ret	05			12	281	9991	1:15 AM		
1	miner	4a Fecility Name (If not institution, give str	eet end number)		4	b. City, Town, or Lo	cation of Death	4c. County	of Deeth			
		Mercy Hospital				Baltimor	e e	N/	/A			
Fune Direc		233-34-6140	7. Age (In yr.	s. last birthday) If Ui Mont	ths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey. 03/27/1	Yeer) 922	9. Birthpiece Country) PA			
pug &		Usuel Residence of Decedent 10a. State 10b. County	10c. (City. Town or Location					10d.	Inside City Limits		
faryl	ō	Md N/A		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						1 ☐ Yes 2 ☐ No		
tha h	50	10e. Street and Number		Baltimore	. Zip Code			0g. Citizen of V	Mat Countral	X		
with with	ā			101				og. Cilizeri di v	mat Country?			
a 23	679	3E Wheeling Street	. Wes Decedent Ever in	II S 12 Was D	2123		oifu Vos os No	USA	e - American I	Indian		
21215-0020 d within 72 hours after death with the Maryland glene. r then "neturel", or thems 23s or 28s-f show	by Funeral Director	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes,	specify Cuba	Ispanic Origin? (Spe n, Mexican, Puerto I Specify:	Rican, etc.)		ck, White, etc.			
2 ho	ted	15. Decedent's Educa	tion	16a. Decedent's	Jsual Occupi	ation		16b. Kind of Bu	siness/indust	ry		
212 Pin 7	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NO	T use retired	during most of working)	ig					
id 212. filed withii Hygiena. other than	NO.	8		Restara	unteur			Foo	odbc			
re, Maryland 212: s 1 and 2 should be filed within f Health and Mantal Hygiens.	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, I	Maiden Sumem	neme)			
ylan ould be Mantal	0	William Tsambikos				Despina	Diakoge					
Maryland d 2 should be file th and Mantal Hy 7 is marked other trainmatic events		19a. Informant's Name/Relationship (Type		19b. Mailing Add	ress (Street	end Number or Rura	Route Number	, City or Town,	Stete, Zip Cod	de)		
Haalth a Haalth a Haalth a		Minas Petropulakis	son	519 Wes	tview	Road, Bel	air, Md	. 2101	21015			
Ha Ha		20a. Method of Disposition	20b.	Place of Disposition cemetery, cremetory	(Neme of or other plec	(e)	Dete	20c. Location -	City or Town,	State		
Pagas hant of int: If its		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval ironi State	aklawn Cem			2/31	Daltima	wa WJ			
Baltimore, Noemit. Pages 1 and Department of Health moortant: If item 27 and and a feet and a feet and a feet and a feet and and a feet and a feet and a feet a feet and a feet a		21. Signature of Funerel Service Licenses			e and Addres		4/31	Baltimo	re, Ma			
m age	d	D- 10	04	Brad:	ley-As	hton-Matt	hews Fu	neral H	ome, I	nc		
-	100	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. 2134 Willow Spring Road, Balto, Md. 2122 Appropriate the such as a such as cardiac or respiratory errest. Appropriate the such as a such as cardiac or respiratory errest. Appropriate the such as a suc										
Physici /Medic Examin	al ier	Immediate Cause (Final disease or condition resulting in deeth) a.		(or as a consequence								
58760, cate be axecuted physician and	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequence	of):							
# 00 g	3	Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or es e consequenca	of):							
Box aath cart attandin	la La								1			
as that the designed by the e	Physician/	Part II. Other significant conditions contri	buting to death but not re	esulting In the underlyi	ng cause give	en in Part I.	23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown					
Records, he law requires that has been signed a has been signed as a state of the law to	leted						24e. Was e perfor		availab	autopsy findings ble prior to etion of cause		
C 0 - 6	E						×.					
- F 60	ပိ	OF Man and and an addition						es 2 No	1 Ye	es 2 No		
Vital Sicien: The certificate irector, pe	o Be	25. Was case referred to medical examiner?	spital:		Othe	26. Place of Death						
of the state of th	-	1 ☐ Yes 2 No 27. Manner of Death	11 Impatient 2	☐ ER/Outpetient 3☐ 28b. Time of	DOA	4 □ Nursing Hor	ne 5 ∐ Reside 8d. Describe h					
ision ttending death. stor: After	Certification:	1 Alatural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Dey Yeer)	Injury M		Yes 2 □ No	28f. Location (Si			oute Number		
To the Hospital or A within 24 hours after To the Funeral Direct Complataly filled in the	I Cert	4 Homicide determined 29e. Cartifier 12 Cartifying Physic	building, etc. (Specian: To the best of my kr	cify)			City or Town	n, Stete)				
Hos 24 h Fun	edicai	(Check only one)	r: On the basis of exemir and manner stated.	nation end/or investiga	tion, in my of	pinlon, deeth occurre	ed et the time, d	ate end pleca,	and due to the	cause(s)		
To the Within 2	ĕ ¥	29b. Signature and Ne of certifier	and marrier states.		29c. License	e number	2	9d. Date signe	d (Month, Dey	, Year)		
F 3 F 8	1	> Joni &	. Drenge	\sim	00	1442		ecomb				
1	0	30. Neme and eddress of person who com			. 1 .	W1 0:0-						
	-	Louis E. Grenzer	301 St. Pau		salto,	Md. 21202						
	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature .								

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A CT SELECTION OF SHORE The same of the sa and party party and a

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 41507 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER **Physician** 1999 CATHERINE M. 3:05 pm /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner BALTIMORE
If Under 24 Hrs. 6403 RIDGEVIEW AVENUE N/A 8. Dale of Birth Month, Day JUNE 20 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral Days Hours 1924 1□ M 2⊠ F Months MARYLAND 75 Director 212206756 Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours efter death with the Maryland nent of Haaith and Mental hygiena.

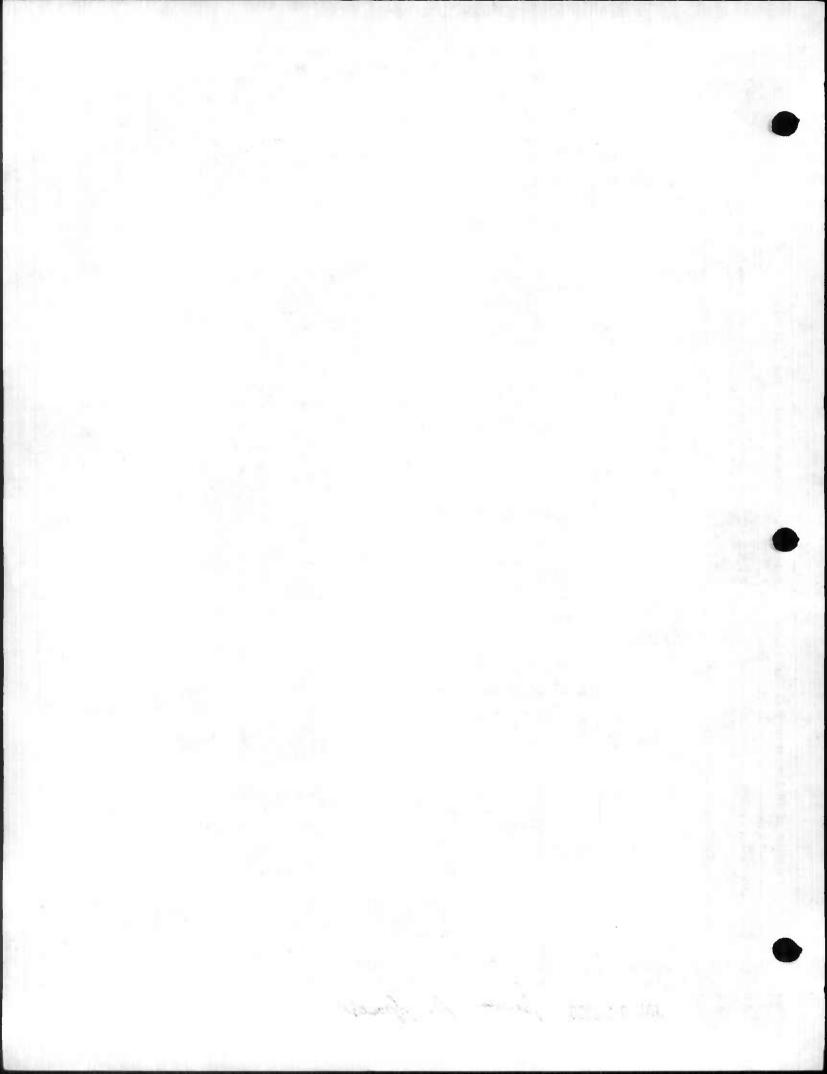
ant: If item 27 is marked other than "natural; or heme 23a or 28a-f ahow ury or other traumatic event, the Medical Examinations and its additional attentions. 10a. Stale 10b. County 10c. City, Town or Location 10d. inside City Limits TOXYes 2 No Director BALTIMORE n/a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6403 RIDGEVIEW AVE 21206 USA Funerai 12. Was Deceden! Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritai Status Bleck, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes 2XXNo Specify: WHITE þ 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 HOMEMAKER 0 OWN HOME Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be WILLIAM CHRISTOPHER SR. LENA BEAN 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 777 Whiteoak Drive BELAIR, MD21014 C. JOYCE YOKA / DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Localion - City or Town, Stale 1/3/00 BALTIMORE, MD 1 Burial 2 Cremation 3 Removal from State pemit. Page Department of Important: If eny Injury or pnca. 4 ☐ Donalion 5 ☐ Other (Specify) PARKWOOD 22. Name end Address of Facility
CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses enuse 1211 CHESACO AVE BALTO, MD 21237 23a. Part1. Enler the disease, or complications that caused the death. Do not enler the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each ine. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical CEREBRO VASCULAR ACCIDENT Examiner Physician/Medical Examiner The law requires that the death certificete be assouted anding physician and use as the buriat-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 68760. Due to (or es e consequence of) Box Part It. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETES MELLITUS þ 24b. Were sulopsy findings evailable prior to completion of cause of death? Completed ARRERY DISZARR 24a. Was an autopsy performed? COROWARY 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physicien: funeral director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Placa of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) After this 28a. Dale of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury al Work? 1 Neiurat 5 Pending investigation To the Hospital or Attending within 24 hours after deeth.
To the Funeral Director: Afte completely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29b. Signature and title of curring 29c. License number 29d. Date signed (Month, Day, Year) 12-31-99 an-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON P. 21M, M. 9634 BELAIR R9, BALTIMORE, NO 21236 BOON 31. Date filed (Month, Day, Year)
JAN 0 4 2000

DHMH 16 Rev 6/95

State Registrar

32. Registrar's Signature

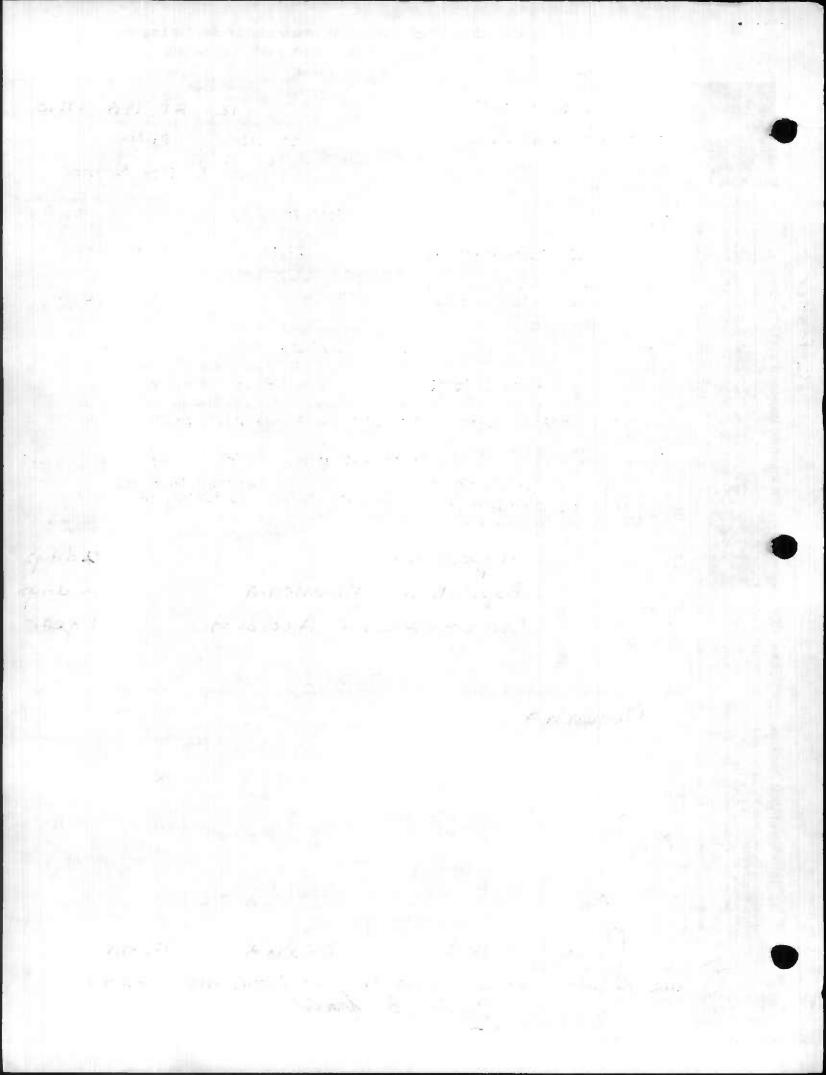


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Registrar

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Piease Type or Print in Biack Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 3. Time of Death 2. Data of Death Month POLLAK MORRIS DECEMBER 29, 1999 7:15 PM 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SINAI HOSPITAL BALTIMORE N/A Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day. Year) AUG. 14, 1914 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sax Days 1X0 M 2□ F Months Hours Yrs. 216-32-5559 Usual Rasidance of Dacedent 10a. Stata 10d. Inside City Limits 10b. County 10c. City, Town or Location BALTIMORE 1X Yes 2 □ No MD N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 6317 PARK HEIGHTS AVENUE U.S.A. 12. Was Decedant Evar in U,S. Armed Forcas? 1 X Yas 2 □ No If Yas, Giva WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, etc. 1 Nevar Married 2 Married WWII 1 Yes 2 No Specify: WHITE Specify: 3 Widowed 4 Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) ALMO PRODUCTS OWNER 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) **HYMAN** POLLAK SARA BERKOWITZ 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6317 PARK HEIGHTS AVE. #602 - BALTIMORE, MD 21215 ANNE POLLAK / WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Mathod of Disposition 1 X Burial 2 Cremation 3 Ramoval from State MOSES MONTEFIORE CEMETERY 01/02/2000 BALTIMORE, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Educated Service Licenses 22. Nama and Addrass of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Efitar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disaasa or condition rasulting In daath) Aortic Stems is Lean Dua to (or as a consequence of): Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 10 3 Probably 4 Unknown Dementic Al 2 herner's 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 1 No 1 TYes 2 No 25. Was casa rafarred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 DER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 10 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 5 Panding invastigation 1 Matural 1 Yes 2 No 2 Accidant 3 Suicida

Physician/Medical þ Be Completed Certification: To

Physician

/Medical

Examiner

Director

Funeral

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Completed

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permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Ite any injury or other traumetic event, the Medical Examine

Physician

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certificate be exec Box 68769

The law requires that the death

confilicate

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica

To the Hospital within 24 hours a To the Funeral D

P.O.

Records,

Vital

Division of

/Medical

Maryland 21215-0020

Baltimore,

6 Could not be determined

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signatura and titla of cartifiar

29a. Certifiar

4 Homicida

29c. License number 030377 29d. Data signed (Month, Day, Year) Dec 30, 99

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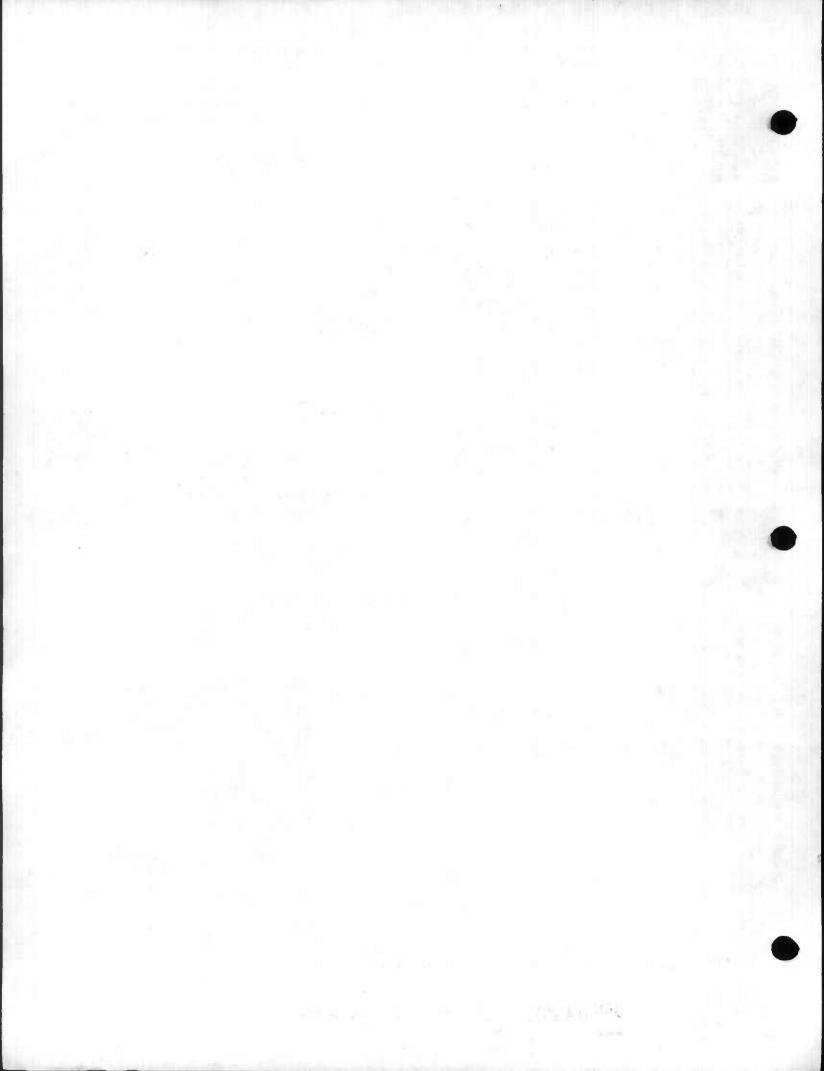
30. Name and address of person who completed causa of death (flom 23a) (Type, Print)
Rubert M. CoopER MD 98 N. Browdway BALT MD 2123/

State Registrar

31. Data filed (Month, Day, Year) JAN 0 4 2000

32. Registrar's Signatura

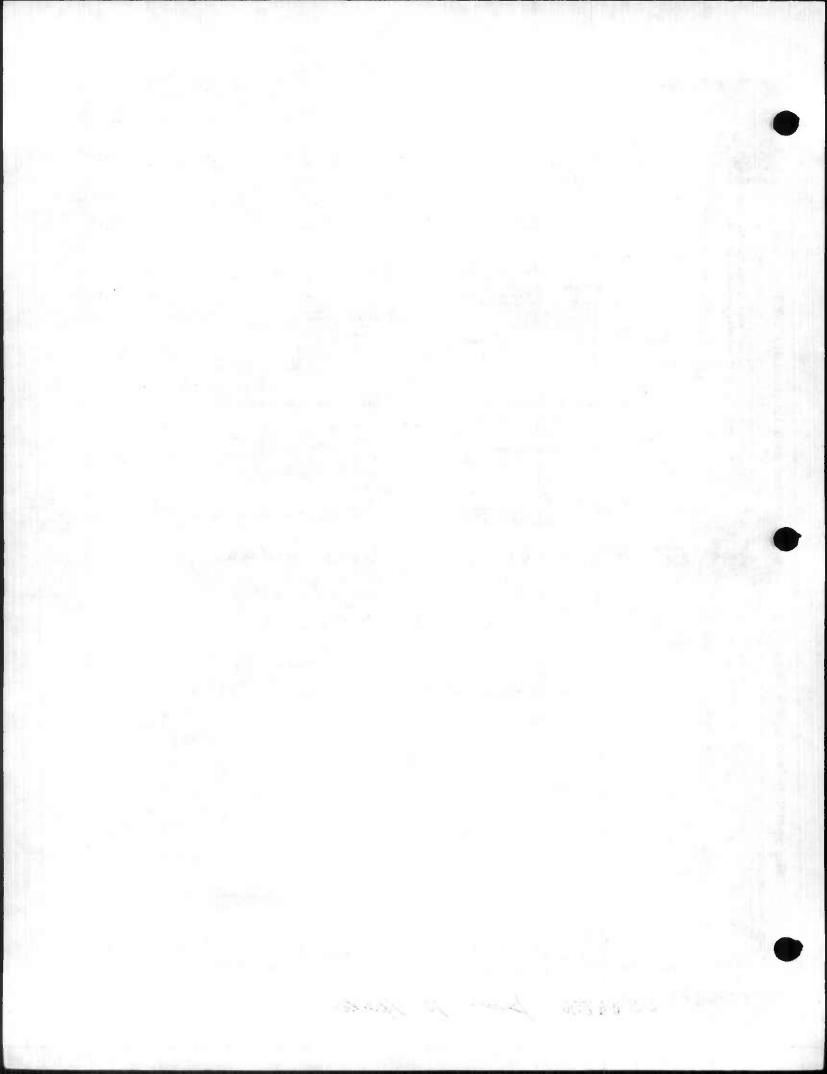
Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



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State of Maryland / Department of Health and Mental Hygiene

					Olato of It	rical y loar		tificate o	f Death		Reg. No.	9 1	:1510
	Dhuataia		1. Decedent's Name	ecedent's Name (First, Middle, Last)					2. Date of De	Death Day Year		3. Time of Death	
	Physicia /Medic	ai	Marie E. Redmond						Decemb			11:30 pm	
	Examine		4a Facility Name (If not institution, give street and number) 4b. City,						4b. City, Town, or	Location of Death	of Death		
			311 Owen						West Ri			Arui	
	Funeral Director		5. Social Security Number 144-32-1657 1 M 2 X F 7. Age (In yrs. last birthday) 92 Yrs. 7. Age (In yrs. last birthday) 92 Yrs. 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Aug. 29, 1907								Year) 9, 1907		lace (State or Foreign try) rgia
	p	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d.										Od. Inside City Limits
	or death with the Maryland therms 23e or 28e-f show one mast be notified at	Director											1 ☐ Yes 2 ☑ No
	5 2 3	9	- 011 0 133 - 3								10g. Citizen of V	Vhat Cour	itry?
	15 v 23 s	_	311 Owens			207			USA				
020	af. or	by Funeral	11. Marital Status 1 □ Never Married ②○SWidowed 4		12. Was Deceder Armed Force: 1 Yes 25 If Yes, Give^Year or Dates	s? No		/as Decedent of Yes, specify C	If Hispanic Origin? (i uban, Mexican, Pue lo <i>Specify:</i>	Specify Yes or No rto Rican, etc.)	14. Raci Blac Specify	k, White,	an Indian, etc. ite
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Ma	d 2 sh th and 7 is m		19a. Informant's Nam						et and Number or F				
9	1 and Health am 27 other tr	ŀ	Eugenia I		rnee (Da	20b. P	Place of Dispos	ition (Name of		Date Date	20c. Location -		
no	Pages vent of mt: If its sry or o			Cremation 3 DF		0		atory or other p	olace)	12/31			
Baltimore,	permit. Pag Department Important: any Injury anse.	-	4 Donation 5 Other (Specify) Metro Crematory 12/31 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A.										
_	00540		Muchele Figure 12 Ridgely Avenue, Annapolis, MD 21401										
)	Physician /Medical Examiner	dical Immediate Cause (Final Consolidate Cause										Approximate Interval Between Onset and Death	
		ě	resulting in death)		An	Que to (o	r as a consequ	ence of):	11				
	ficate be executed physician and is the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that imitiated events Due to (or as a consequence of): Due to (or as a consequence of):										
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68760,	ificate be executed g physician and as the burial-transit	edica	that initiated events resulting In death) La	st		Due to (o	r as a consequ	ence of):	1001			1	
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0	tha death cert y the attendin ached for usa	Physician/M	Part II. Other significa	ant conditions cor	ntributing to death	but not res	ulting in the un	derlying cause	given in Part I.	23b. Did	obacco use cor	11ributa 1	the cause of death?
a	as that the death cert igned by the attending be detached for use	by Ph								. 10	1 Yes 2 NO 3 Probably 4 U		
Records,	law requires that as been signed b 2 ahould be deta	Completed									an autopsy med?	av co	ere autopsy findings allable prior to mpletion of cause death?
	The law ate has page 2	E								10	res 2 DNo	1[Yes 2□ No
Vital	iclan: The	99	25. Was case referred	d to medical					26. Place of De	eath (Check only o	ne)		
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ou of	ding Ph. After this funeral		27. Manner of Death 1 2 Natural 2 Accident	5 Pending investigation	28a. Date of fr (Month, E	jury Day Year)	28b. Time of Injury	28c. lr	ijury at Vork? □ Yes 2 □ No	28d. Describe	now injury occur	red	
Division	To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely f	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of t building,	njury - At ho etc. (Specif	ome, farm, stre	et, factory, offi	>8	28f. Location (: City or To		er or Rur	Il Route Number,
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ľ	State	е	31. Date filed (Konto			trar's Signa	drawn.	parks					T



Piease Type or Print in Biack Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yes Physician ROBINSON GERALDING DEC 30 1999 01=43 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours 1 Adi: 8. Date of Months Days 1 Adi: 8. Days 1 Adi: 5.1 FALLSTON
5. Social Security Number 6. Sex FOLD HAZ 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** 1 ☐ M 2 🗆 🖹 218-26-9363 Director JULY 8 1932 MARYLAND Usual Residence of Decedent the Manyland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow "natural", or items 23a or 28a-f aboved at 1 Yes 2 No Director MARYLAND HARFORD CO **EDGEWOOD** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 1612 SWALLOW CREST DRIVE 21040 apt D U.S.A. Funerai 12. Was Decedent Ever in U,S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus Bleck, Whita, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: 1 Never Merried 27 Married 21215-0020 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) HEALTH NURSE 12th it of Health and Mental Hyg If Item 27 is marked other or other traumatic event, Baltlmore, Maryland 17 Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental CHARLES NELSON HENRIETTA NELSON SCRIVER 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis Robinson Jr./Son 6 Autumn Blaze Ct., Woodstock Md., 21163 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 1 Deriver 2 Cremetion 3 Removel from State permit. Page Department of Important: If any Injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) KING MEMORIAL PARK 1-4-00 BALTIMORE, MARYLAND 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical ALTEMOSCLEROTIC CARDIOVADOLLAR Examine Due to (or as a consequence of) DISEADE Examine physician and s the burial-transit be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Box 68760, Physician/Medical The law requires that the death certificate Due to (or es a consequence of): 9 USB signed by the at d be detached for P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? should Completed page 2 certificate 1 Yes 2 No 1 Yes 25 No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 No Certification: To 1 ☐ Inpatient 2 ☐KER/Outpatient 3 ☐ DOA this 28e. Dete of Injury (Month, Day Year) 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Neturel 2 Accident after death. 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29e. Cartifier completaly (Check only one) Within 2 \$ 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier DME OCME DEC 30 1999

State Registrar

DHMH 16 Ray 6/95

FULFOLD ANE BELLININD 21014

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

218

32. Registrar's Signeture

MA BHU

31. Dete filed (Month, Dey, Year)

JAN 0 4 2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Charles Schneiden December 30 1999 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Bayview Med Center Baltimor If Under Months 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Forman Country) Days Hours 10 M 20 F 89 212-03-7148 MD Usual Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Dunda1k 10e Street and Number 10f. Zin Code 10g, Citizen of What Country? 3011 Baybrier Road 21222 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Dates: 1 Never Married 2 Merried 1 Yes 2 QNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Stationary Engineer State 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Name (First, Middle, Last) Frederick Schneider Marie Borkman 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 1822L 19e. Informant's Name/Relationship (Type, Print) Barbara Runchel/Daughter 17630 East Loyola Dr, Aurora, Colorado 80013 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) Balto-Washington Crematory 01/05 Laurel, Md. ature of Funeral Service Licensee 22, Name and Address of Facility Bradley-Ashton-Matthews Funeral HOme, Inc. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on each line. 21222 Approximate Interval Between Onset and Death Immediate Cause (Final desease (acute myocardiolingarct artery disease or condition rasulting in death) Dua to (or as a consequence of): WBEKS Bleed Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa raferred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Durild 27. Mangar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Matural 5 Panding investigation

1 ☐ Yes 2 ☐ No

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Location (Street and Number or Rural Route Number, City or Town, Stata)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Physician

Funeral

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

the Maryland

filed within 72 hours efter

Hygiene.

permit. Peges 1 and 2 should be filled wit Department of Health and Mentel Hygiens important: if item 27 is marked other that eny injury or other traumatic event, that once.

altimore, Maryland 21215-0020

/Medical

the P.O. signed by t Records, page 2 s certificate Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this cartifica ately filled in by the funeral director.

þ Be Completed

Examiner Physician/Medical edical Certification: To

To the Hospital within 24 hours e To the Funerei Completely filled in the Completely filled in t

State Registrar

31. Dete filed (Month, Day, Year)

2 Accident

4 Homicide

29b. Signature and title of certifiar

3 ☐ Suicide

29a. Certifier

6 Could not be

who complated cause of death (Item 23a) (Type, Print) Johns Hopkins Bayriew Med Center. 00

32. Registrar's Signature

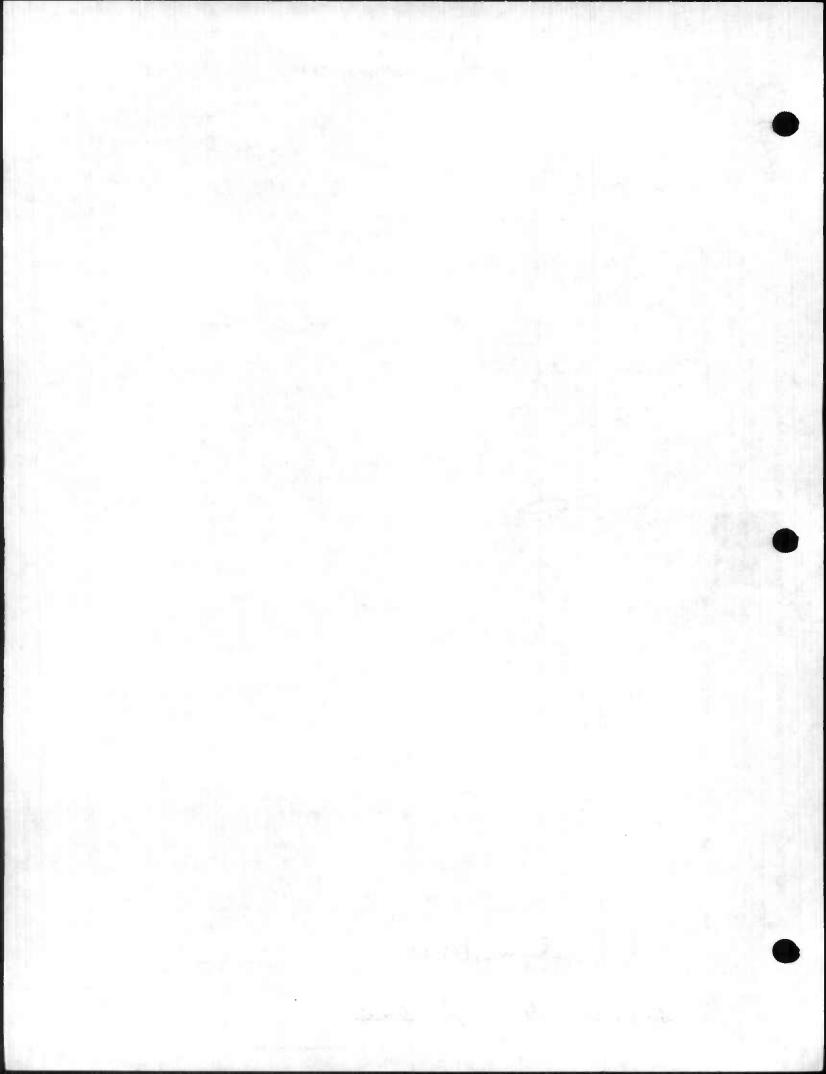
28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physician	1. Decedent's Neme (First, Middle,		2. Date of De Month	Death Dey Yaer 3. Time of Death							
/Medical	Alice St. Clai			Decemb	1	1999	10:30 A.M				
Examiner	4a Facility Nama (If not institution,	giva street and number)			1	4b. City, Town, or	Location of Deet	4c. County	of Deeth		
•	Johns Hopkins					Balti			/A		
Funeral Director	unk	5. Sex 7. Ag	ge (In yrs. last b	Yrs. Mon	nder 1 Year ths Days			th by, Year) 2, 1926	- Counti	Virginia	
Du B	Usuet Residence of Decedent 10a. Steta 10b. County		10c. City, Toy	wn or Location					10	Od. Inside City Limits	
e Maryl te-f sho diffied a	MD E	Baltimore	Wood]							1 ☐ Yas 21 No	
3 inflar death with the Marya riters 23a or 28a-f sho iner must be notified at Funeral Director	10e. Street and Number 6417 Lehnert S	Street			Zip Code 21207			U.S.A		ry?	
020 urs after des st', or items Examiner in by Fune	11. Meritel Stetus 1 Never Merried 2 Merrie 3 XWidowed 4 Divorced	12. Was Decedent Armed Forcas? d 1 ☐ Yes 2 ☑ If Yes, Give Year or Datas:				Hispenic Origin? (Spen, Mexican, Puar Specify:	Specify Yes or No to Rican, etc.)	ce - American Indien, sck, White, etc. fy: White			
1 21215-0 sid within 72 to typiene. we then 'natur v. the Medical. Completed	15. Decedent's (Specify only highest	Education	166	Decedent's	Jsuel Occu	petion	dkina	16b. Kind of B	usiness/Indi	ustry	
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yla Men Men Men Men Men Men Men Men Men Men	Antonie Yakubow	ski				Lillie	Helen S	Smith			
Mary and 2 shoul alth and M 27 is ment or traumed	19s. Informant's Name/Relationshi Joyce Reed (Dau					oad, Esse		er, City or Town, 21221	Stete, Zip	Code)	
timore, Fages 1 at triment of Heat sant; if them saint; if the saint; if t	20a. Method of Disposition 1 🖾 Buriel 2 □ Cramation 3 4 □ Donation 5 □ Other (Spi	Dete 1/10/00	20c. Location - City or Town, State 0/00 Owings Mills, MD								
Balti pemit. Departm imports any inju	22. Nama and Address of Facility Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 2122										
MD	23a Parti Enter the Usesse, or c								e, MD	21228 Approximete	
Physician and physician and s the burial-transit edical Examiner	Immediate Cause (Finel disease or condition resulting in death) Smoke Inhalation and Thermal Injuries Due to (or es e consequenca of): Due to (or as a consequenca of):										
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sed fine a /sic	Part II. Other significant condition	contributing to death b	iven in Pert I.	23b. Did tobacco use contribute to the cause of death							
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2 2 0 2 -	3 Suicide 6 Could no	ot be					_	Subject was in a house fir 281. Location (Street and Number or Bural Route Number, City or Town, Stete) 6417 Lehnert St			
or A partier in the p	4 Homicide determin	building, e	28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) HOME								
Div To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certi	(Check only 2 XMedical E	Physician: To the best	f examinetion s				e, end due to the		enner as sta	ated.	
thin 2 thin 2 mplet	20h Signature and title Portifier	and menner st	eted.		200 1 100	ise number		29d. Dste signe	ad (Manth I	Day Veerl	
5 × 5 0	29b. Signature end title of certifier	+	MA								
1	7.17	Menne	1111-7),		O.C.M.E.		Decemb	er 28,	, 1999	
10	30. Name said address of person w	ho completed cause of	desth (Item 23e)	(Type, Print)							
4	Joseph Pesta			111	Penr	Street,	Baltimo	re, Mar	yland	21201	
State Registrar	JAN 04 2000	Server 32. Registe	rer's Signature	Sport	2						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month **Physician** DECEMBER 27 22:03 1999 Minnie E. Stancliff /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. AGNES HEALTHCARE BATIMORE If Under 24 Hrs. Hours Min. 8. Data of Birth (Month, Day, Year) May 19, 19 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthpleca (State or Foraign Country) Maryland **Funeral** Days 1□M 2ØF Months 82 Director 215-05-6395 Usual Residence of Deceden the Manylend 10d. Inside City Limits 10a Stata 10b. County 10c. City. Town or Location ehow 7 is marked other than "natural", or flams 23s or 28s-f shot traumstic event, the Medical Examinar must be notified at 1 ☐ Yas 2 ☑ No Director Maryland Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 911 Regina Drive 21227 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mentai Hygiene. Important: If them 27 is marked other than "natural", or then eny injury or other traumatic avant Black, White, atc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ♥ No Specify: Specify þ 3√ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Seamtress Clothier 18 Mother's Name /First Middle Maiden Surname 17. Father's Name (First, Middla, Last) Be Ettlin Rose Taylor Nathan 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routs Number, City or Town, State, Zip Code) Toby F. Witte/Daughter 911 Regina Drive Baltimore, Maryland 21227 20b. Placa of Disposition (Nama of cematery, crematory or other placa) 20a. Method of Disposition Data 20c. Location - City or Town, Steta 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 12/29/99 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue Baltimore, Maryland 21229 uanuta nomas intle the disease, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, but, in heart failure. List only one cause on aech line. Approximate Intarval Batween Onset and Death Physician //dedical tmmediate Causa (Final diseasa or condition resulting in death) NIEROSEDIAL /YOCARDIAL Due to (or es a consequence of): INFARCTO! FRDIOGRAVIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of degth? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Onknown È signed b à 24b. Ware autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy performed? **Dage 2** 1 Yas 2 No 1 Yas 2 No 25. Was case referred to medical 88 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ž 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Athar 1 Natural 5 Pending Mospital or Antional Property And Director: Antibertor: Antibertor 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Mospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. edical 29a. Certifier 29d. Data signed (Month, Day, Year)

DECEMBER, 27/K 29b. Signature and title of certifier 29c. License number D18319 1999 Trullmita & STHENES HOSPOTHE and address of person who come ed cause of death (Item 23a) (Type, Print)

State Registrar WIL Kumaiz

JAN 0.4 2000

. Data filed (Month, Day, Year)

DHMH 16 Rev 6/95

ATTERPAREIZ

32. Registrar's Signature

900 CAPOLY HIE BASTMORE

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death December 29, 1999 **Physician** Leo Schwartz 3:50pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospice of the Chesapeake Linthicum Anne Arundel If Under 1 Year If Undar 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Months Days Hours 1√2 M 2□ F 113-05-4104 80 Feb.16,1919 New York Usual Rasidence of Decedant 10c. City. Town or Location 10a. Stata 10b. County 10d. Insida City Limits 1 ☐ Yas 2 No Directo Anne Arundel Annapolis 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 907 Mastline Drive 21401 USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puarto Rican, atc.) 14. Race - American Indian, 12. Was Decedant Evar in U,S. Armed Forcas? 11 Marital Status Black, Whita, atc. 1√Xas 2 No 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify. White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Elementary/Secondary (0-12) Collega (1-4or 5+) Master Sergeant U.S. Army 18. Mother's Neme (First, Middla, Maiden Surnama) 17. Father's Name (First, Middle, Last) Joseph Schwartz Sophie Sherr 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Florence T. Schwartz - Wife 907 Mastline Drive, Annapolis, MD 21401 20b. Place of Disposition (Nama of cematary, cremetory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data N Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Other (Specify) 1/3/2000 Meadowridge Memorial Elkridge, MD 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Hardesty Funeral Home, P.A. 851 Annapolis Road, Gambrills, 21054 hel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediata Cause (Final disaasa or condition rasulting in death) Dua to (or as a consequenca of) Physician/Medical Examiner Sequentially list conditions, if any, laeding to immadiata causa. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequenca of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown δ 24b. Wara autopsy findings evellable prior to complation of causa of death? 24a. Was an autopsy performed? Completed 25. Wes case refarred to medical axaminer? Be 26. Placa of Death (Check only one) 1 Yas No Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 6 Nother (Specify) HBSP(U) Medical Certification: To 28a. Data of Injury (Month, Day Year) 27. Magner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending invastigation 1 Tas 2 No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

The law requires that the death certificate be executed Box 68760. attending physiclan signed by the a d be detached f P.O. Division of VItal Records. peen certificate has or Attending Physician: this After s after death. To the Hospital o within 24 hours at To the Funeral Di

Funeral

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Department of Important: If the any Injury or o

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Maryland

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State Registrar

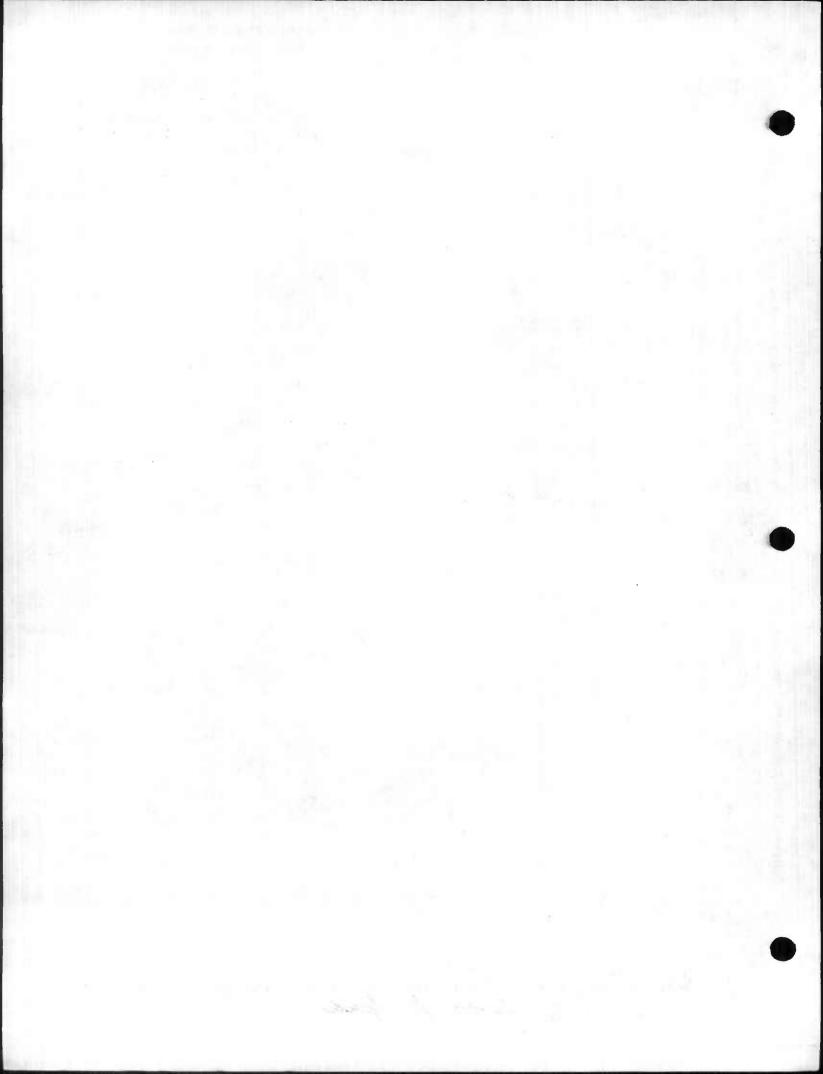
30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print) 900 -. Graze 31. Data filed (Month, Day, Year) JAN 0 4 2000

32 Registrar's Signature.

1 Certifying Phyelcian: To the best of my knowledga, death occurred et tha tima, data and place, and dua to the cause(s) end mannar as stated.
2 Hedical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the tima, date and place, end dua to the cause(s) and mannar stated.

druegolo, MD 21407

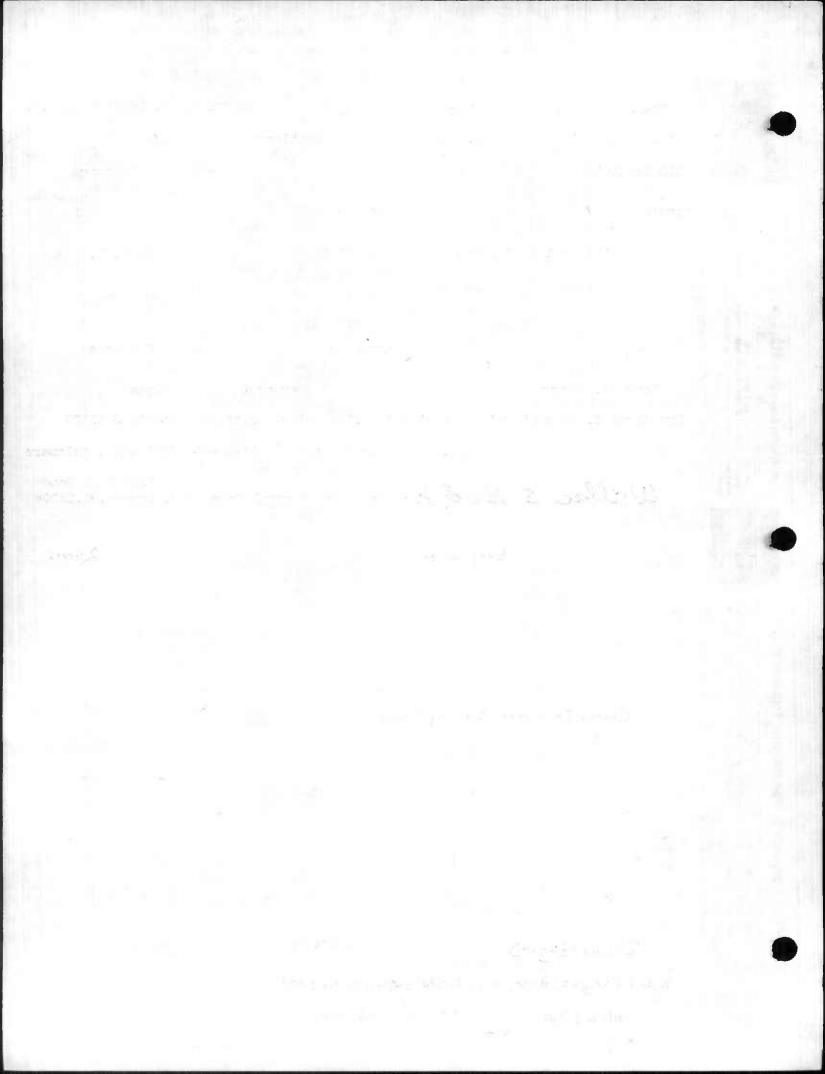
29d. Data signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** December 23, 1999 8:15 p.m. Jeane В. Shamberg /Medical 4a Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner lll Hamlet Hill Road Apt. 902 Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 3-4-1923 **Funeral** Days Months Hours 1 M 2 F Yrs. 222-14-6041 76 Director Delaware Usual Residence of Decedent death with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow event, the Medical Examiner must be notified at Maryland N/A Baltimore 1DXYes 2□No Director 10e. Street and Number 10f. Zip Code 10n Citizen of What Country? ò lll Hamlet Hill Road Nems 23s 21210 U. S. A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hyglene. Important: If Item 27 ie marked other than "natural" or in any Injury or other traumatic avenue. Black, White, etc. 1 Yes 2 No
If Yes, Give X
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 17 Father's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Mark P. Brown Margaret 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs Carol S. Wertheimer (Daughter) 8 Greenlea Drive, Baltimore, Maryland 21208 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State St. Joseph Brandywine 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-28-99 Wilmington, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Lung Concer 2 years disease or condition resulting in deeth) Examiner Due to (or as e consequence of): Examiner attending physician and for use as the bunal-transit The law requires that the death certificete be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1K Yes 2 No 3 Probably 4 Unknown Chronic Obstructive Pulmonery Ducox þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 1 Yes 2 No 1 □Yes 2 □ No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4□ Nursing Home 5 Residence 6 □Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 20604 12/24/99 Kichend a Bay in D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Richard A. Berg, 40; #450; 10755 Felled; Lutherville, had 21093 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State ooks Registrar JAN 04 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Frederick Martin Stein, Sr. 03 15 DECEMBER 29 1999 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE AGNES HEALTHCARE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□XM 2□ F Yrs. Director 220-22-9727 Sept. 5, 1929 70 New York Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examiner rount be notified at 1 Yes 2 No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2657 Norland Road 21230 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritai Status filed within 72 hours after Hygiene. I Tyes 2 No If Yes, Give Year or Dates: Korean 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: White þ 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) Hydraulic Engineer General Elevator 8th Ω 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be fi n end Mental I is marked of Walter Stein Anna Geisler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 sh Department of Health end Important: If item 27 is m any Injury or other traum once. 972 Tidewater Road Pasadena, Maryland 21122 Virginia Heil (Sister) 20a. Method of Disposition

1 A Buriai 2 Cremation 3 Removal from State 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Cedar Hill Cemetery 12/31/99 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue Baltimore,Maryland 21225 mitina A. Willow 23a. Part1. Entar the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Physician CHRONIC OBSTRUCTIVE PULMONARY DISEASE Immediate Cause (Final disease or condition resulting In death) /Medical 4 WEEKS Examiner Due to (or es e consequence of) Examiner ettending physicien end for use es the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) resulting in death) Last Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uas contributa to the causa of death? of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en autopsy Completed 1 Yes 2No 1 ☐ Yes 2 No NAME FREDERICK 25. Wes cese referred to medical Be 26. Piece of Deeth (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No To 28c. Injury et Work? 27. Manner of Deeth 28b. Time of Certification: 1 Naturai 2 Accident 5 Pending Investigation death. 1 ☐ Yes 2 ☐ No ofter death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ HomicIde within 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end menner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dec. 29,1899 MEDICAL RESIDENT 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

OFFEI ADDO, MD, 900 CATON

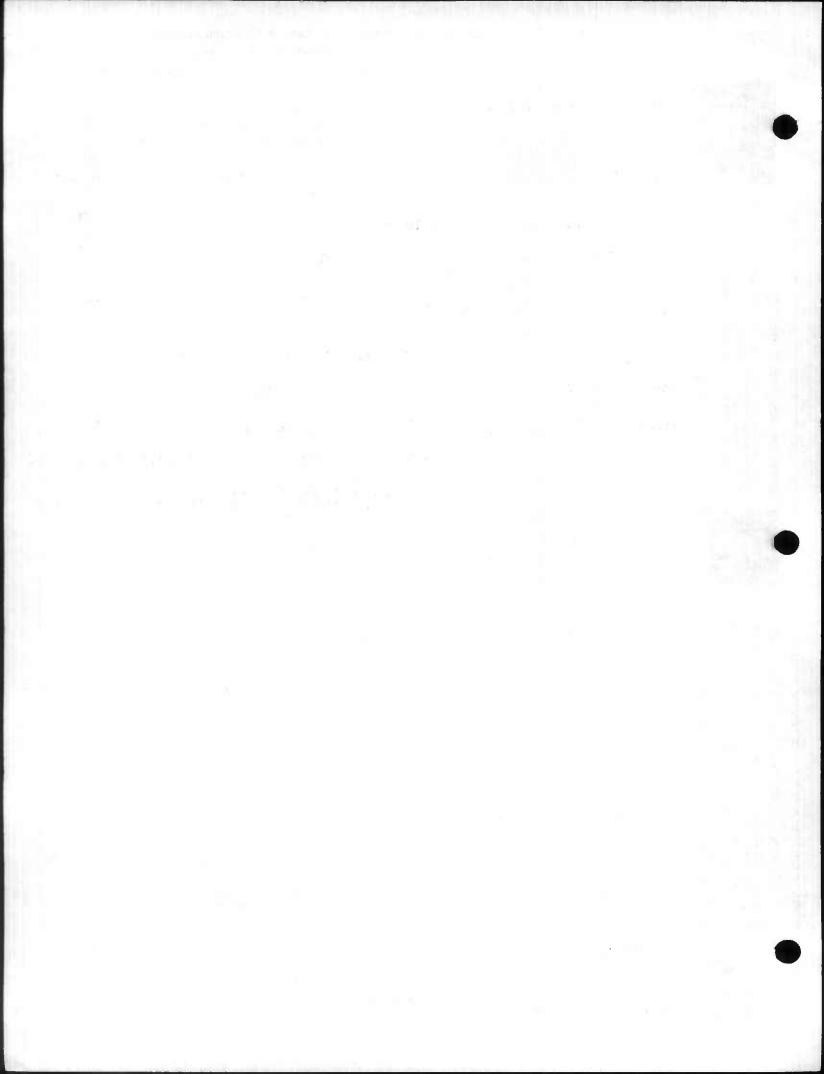
32. Registrar's Signature

AVE, BALTIMORE

21229

State Registrar RICHARD

31. Date flied (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Smal 12:30 PM 29,1119 December 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore, CHY S Hospitul 7. Age (In yrs. lest birthday) THE JOHNS 5. Social Security Number N/A HOPKINS 8. Date of Birth (Month, Day, Year) MAR. 23, 1 If Under 1 Ye Birthplace (State or Foreign Country) 10 M 2MF Months Days Hours 215-01-2158 86 MASS. Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits N/A BALTIMORE 1 ☐ Yes 2 ☐ No 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4009 FALLSTAFF ROAD 21215 U.S.A. 14. Race - American Indian 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE 3 NWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COSMETOLOGIST COSMETOLOGY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PHILLIP COHEN SARAH RESNICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MINDY K. ROBERTS / DAUGHTER 16807 LEHIGH DRIVE - SANDY SPRING, MD 20860 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 D'Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) SHAAREI TFILOH CEMETERY 12/31/99 WOODLAWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Pulmonny Obstructine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tohecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

permit. Pages Department of Important: If it any injury or o

Physician

/Medical

Examiner

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Funeral

Director

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Pages 1 and 2 ahould be filed within 72 hours effer death with interior of health and Mental Hygiene.
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Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records.

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physician and the burial-transit signed by the attending p d be detached for use as this certificate

Physician/Medical Examiner Completed by 8 Certification: To

27. Manner of Death

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2 T Accident 3 T Suicide

4 - Homicide

funeral After a after de-al Director: After the fu

Hospital of 24 hours a Funeral D Medical complately within 2

filled in by

Registrar

29a. Certifier (Check only one) 29b. Signature and title of certifi-

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

26a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

28h Time of

1 Yes 2 No Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MA

28d. Describe how injury occurred

29c. License number M.D

KES-000

29d. Date signed (Month, Day, Year) December 29, 1991

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Mobilliams M.D. Tower 110, 600 N. Wolfe

31. Date filed (Month, Day, Year)

JAN 0 4 2000

32. Registrar's Signature Gener

St Baltmore, ouks

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 4:1519

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Funeral Director	5. Social Security Number 125–18–6551 6. Sex 11/1 M 2	7. Age (In yrs. las	yrs. If Unde Months	Days	If Undar 24 Hrs. Hours Min.	8. Data of Birth (Month, Day, FEB. 12,	Year) 1914	9. Birthplaca Country)	(Stata or Foreign	
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To the Hospital or Attending Ph. Within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	29a. Certifier (Check only one) Check only one) 15 Certifying Physician: To the Continuous Physician Physician Continuous Physician Continuous Physician Physici	the best of my knowled the basis of axamination manner atated.	edge, death occurred n and/or investigation	at tha tim	ne, data and place, pinion, death occur	and dua to the ca red at the time, da	use(s) and ma ite and place,	anner as stated and due to the	cause(s)	
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State		2. Registrar'a Signatur	e 4 1	- 4	/ .					

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State of Maryland / Department of Health and Mental Hygiene

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	Examin		4a Facility Name (If not institution								ocation of Deat	h 4c. County						
	<u> </u>		MARINER HEAI				T William AV		BALT				N/A					
	Funeral Director		5. Social Security Number 212-05-6075	6. Sex XXDM 2□F	7. Age (In yrs. 90	last birthday; Yrs.		ear	If Under Hours	Min,	8. Dete of Bit (Month, De 06-01	th ay, Year) L-1909	Cour	9. Birthplace (State or Foreign Country) MARYLAND				
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or L	ocation						11	Od. Inside City Limits				
	he Maryl	Director	MD. BALT		TONSVILLE 1 Yes XX No													
F 22	1 0 0 E	2	10e. Street and Number		2012		10f. Zip Co		200			10g. Citizen of What Country?						
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21215-0020 within 72 hours after de plens. It then "netural", or frem the Medical Examiner.	filed within 72 hours after death with the Maryland hygienn. ther than "naturel", or fleme 23a or 28e-f show int, the leafing Earling must be motified a	by Funeral	11. Marital Status 1 Never Married 2 Merri 3 Widowed X Divorced	Armed Fo	rces? XXNo /e		ff Yes, specify (Cuban	, Mexicar	n, Puerto	Rican, etc.)		ck, White,					
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and	d be d	Be	JOHN HENRY	TAG					ANN		MARTH?			AUSEN				
Maryland	hould Me	2	19a, Informant's Name/Relationsh			19b Meili	ing Address (St	reet at				er, City or Town,						
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	within To the compli	ž	29b. Signature and title of certifier	. 1			29c. Lic	ense	numbar			29d. Date signe	d (Month,	Day, Year)				
	1		k on	al le-T	aul.	wo	D	18	36	2		JANUAR	Y 3,	2000				
	10	1	30. Name and address of person y	the completed caus	e of death (Iter	n 23a) (Type,	Print)	, 0	- 0									
	Ψ		KOMAL K. DANG	,M.D.,3	455 W1	LKINS	AVEN	UE,	, BA	LTI	MORE,	MARYLA	ND,	21229				
	Stat	e	31. Date filed (Month, Pay, Year)	32. R	egistrar's Signa	atore 1	oaks											

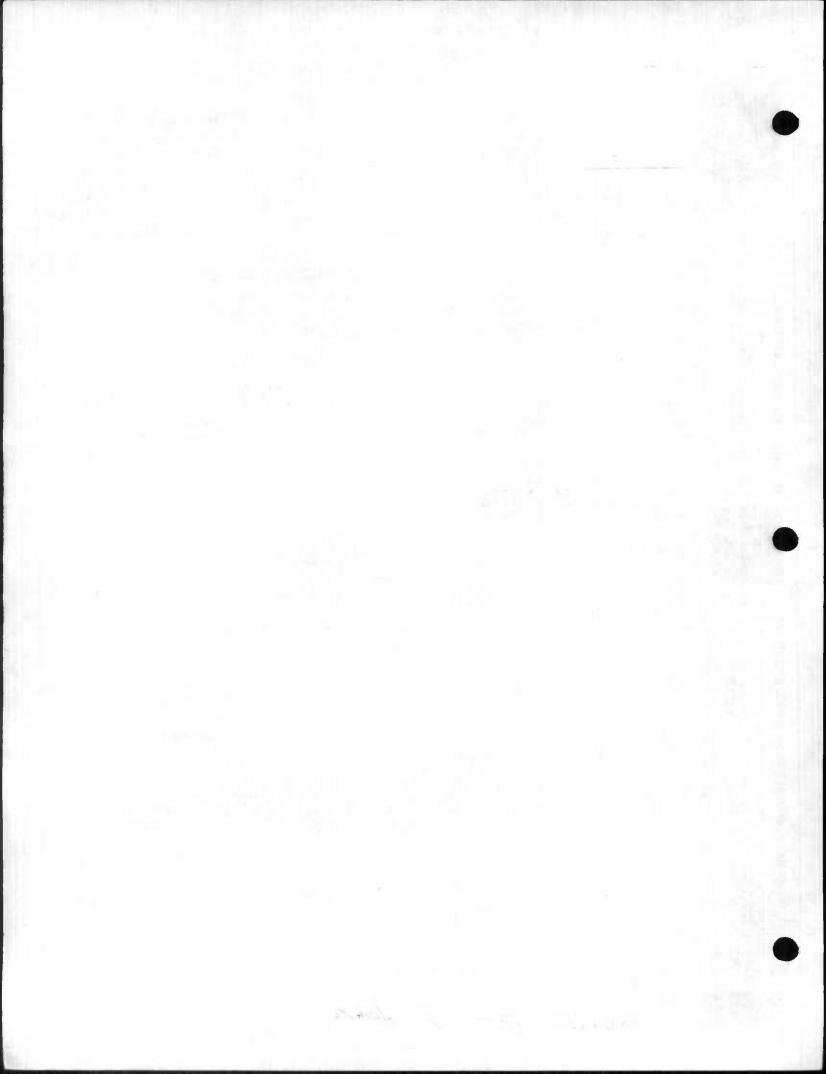
DHMH 16 Rev 6/95

Marriage to the A. topic, a sec-

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AMENDED IT	EM # 5 PE	R FH G779 1	1/21/2000		f Marylan		artment of rtificate or	Health and Death	Mental Hy	giene	9 4	:1521
- 10	Physician	1. Decedent's Na	ma (First, Middl	a, Last)	lo				2. Data of De Month		Year GG	3. Time of Death
	/Medical Examiner	4a Facility Nama	(If not institution	n, giva street and nu Medical C	major			4b. City, Town, or	Location of Deat	h 4c. County		2.30 pr
	uneral irector	5. Social Security		6. Sex (XX)M 2□ F	7. Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Day		8. Data of Bir		9. Birthol Count Alaba	lace (Stata or Foreign try)
death with the Maryland	23a or 28a-f ahow ant be notified at ai Director	Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. In										0d. Inside City Limits 1XXX as 2 □ No
with the	23a or 28a-fi unt be notifie rai Directo	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 First Street 21401 USA										iry?
15-0020 n 72 hours after	ar, or terms. The Funer by Funer	11. Marital Status		12. Was Dec	24 No va			Hispanic Origin? (S ban, Mexican, Puan	specify Yas or No to Rican, atc.)			
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aryland	important; if lean 27 is marked other than any injury or other traumatic avent, the M ands. To Be Comp	17. Fathar's Name Louie E						18. Mother's Nar Ella L.		, Maidan Suman	na)	
, Mar	or traum	19a. Informant's I		hip <i>(Type, Print)</i> (Mother)				et and Number or Ru eet, Anna				Coda)
altimore,	ant: If Iten ary or oth		•	3 Removal from pecify)	Stata	ematary, crei	sition (Nama of matory or other po Cemeter		Data 01/04	20c. Location		
Balt Pemit.	any injector	21. Signature of F	Funaral Sarvice	9. Kul	to	22		rass of Facility Ly Funeral gely Avenu			4D 214	401
600, Example of the sample of	for use as the burist-transit and position for use as the burist-transit and position for use and p	23a. Part1. Entar shock, or he limmediata Causa diseasa or condit resulting in death Sequentially list of if any, leading to cause. Enter Uncause (Disease othat initiated even resulting in death)	a (Final ion) conditions, immediate derlying or Injury its	only ona cause on a	Dua to (or		Jhod quence of): Cardust quence of):	myopas	to or raspiratory a	rrast,		Approximate Interval Between Onset and Death Shows Unknown Inknown
O. B.	d by the attending pletached for use as letached for use as Physician/Me	Part II. Other sign	ificant conditio	ns contributing to de	eath but not resu	ilting in tha u	nderlying causa (given in Part I.	23b. Did tobacco use contribute to the cause of death?			
ords, P	been signed by the attending p should be detached for usa as leted by Physician/Me	Diabetes Welluhus 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1									ara autopsy findings ailable prior to	
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of Vita	director	25. Was casa refa axaminer? 1 \(\text{Yas} \) 2		Hospital: 1	Inpatient 2	ER/Outpatier	I 3LI DOA	ther: 4 Nursing I	ath <i>(Check only</i> doma 5 ☐ Rasi		nar (Specify	1)
Division of Vital Records, P.O. Box 687 billed of the law requires that the death certificate a after death.	To the Funeral Director: After the completely filled in by the funeral Medical Certification:	27. Manner of Dec 1 Natural 2 Accident 3 Suicide 4 Homicide	5 Pendin Invastion	not be 28e. Place	of Injury th, Day Year) of Injury - At ho ing, atc. (Specify	28b. Tima o Injury ma, farm, str	W]Yas 2□No	28f. Location (how injury occur Street and Numi wn, Stata)		l Routa Number,
To the Hospital	the Funer spletely fill	29a. Certifier (Check only one)	2 Medicat	Examiner: On the band man			vestigation, in my	tima, data and place opinion, death occu		data and place,	and dua to	tha cause(s)
0 23	To To M	29b. Signatura an	Sulle	L	Jam	9	D41	L534		29d. Data signe	31/16	Jay, Year)
	State Registrar	30. Nama and aski	nth, Day, Year)	/1	sa of death (Item	23a) (Type, MD tura	Aparks	Medical of	Darkun	1 Suik	350	Annapolis

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death PECEMBER Pay **Physician** Victoria Anne Thomas /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PHINCE GEORGES SUREL HOSPITAL REGIONAL SURE if Undar 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Yaar) Birthpiaca (Stata or Foraign Country) 5. Social Sacurity Number 7. Age (In vrs. last birthday) **Funeral** Min. Davs Months Hours 1□M XXXF 49 214-54-7468 Aug. 6,1950 Director Pennsylvania Usual Rasidanca of Dacedant the Maryland 10d. Inside City Limits 10a. State 10c. City. Town or Location 10b. County must be notified at 1 Yas 2 No Director MD Anne Arundel Laurel 10e Street and Number 10f Zin Code 10g. Citizan of What Country? With 20810 8612 Woodland Manor Drive IISA death Funeral r than "natural", or items the Medical Examiner ma 12. Was Dacedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Give 14. Race - Amarican indian, Wes Decedant of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 11 Marital Stetus Biack, White, etc. filed within 72 hours after 1 Navar Married 2 Married Specify: Black Baltimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: by 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) I Hygiena. Eiamantary/Sacondary (0-12) Collega (1-4or 5+) Senior Logistician Dept. of Defense Pages 1 and 2 should be filed and 10 feel of Health and Mental Hygient: If Item 27 is marked other? 17 Fathar's Nama (First Middle Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Be Ewing James Thomas, Sr. Ida Anna Montgomery 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Ewing J. Thomas, Sr. (Father) 1302 Burlington Drive, Odenton, MD 21113 other 20c. Location - City or Town, Stata 20a. Mathod of Disposition 20b. Place of Disposition (Nama of Data cematary, cramatory or other placa) 1 XBuriel 2 ☐ Cramation 3 ☐ Ramoval from State 0 permit. Page Department of Important: If any injury or once. 01/05 Epiphany Episcopal Cem. Odenton, MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funarai Sarvice Licansee 22. Nama end Addrass of Facility Hardesty Funeral Home, P.A. La 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or rasptratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** /Medical Immediata Causa (Finai HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disaasa or condition rasulting in daath) Examine Dua to (or as a consaquanca of): Examiner physician and s the bunal-transit that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Diseasa or injury that initiated avants rasulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequence of) usa as 5 signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 0 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records. by 24b. Wara autopsy findings availabta prior to 24a. Was an autopsy Completed completion of cause of death? has page 2 1 □ Yas 2 □ No certificata Hospital or Attending Physician: director, 25. Was casa rafarrad to madical examinar?

1 No 26. Placa of Daath (Check only ona) Be Other: 4 Nursing Homa 5 Residence 6 Other (Specify) P 1 Innatiant 2 ER/Outpatient 3 DOA this funaral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Affer 1 Natural 2 Accidant 5 Panding invastigation after death. 1 Yas 2 No 3 Suicida 6 Could not be datamined 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) completely filled in by 4 Momicide 24 hours a edlcai 29a, Cartifiai 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I ‡ 29d. Date signed (Month, Day, Year) 29b. Signature 29c. Licanse number 0 who complated cause of death (item 23a) (Type, Print) ITAL DRIVE CHOVERLY, MARYLAND 3001 M MARIO 32. Registrar's Signature

State Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** Doris Brown Towers December 10:45 pm /Medical 4e Facility Nema (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel Chesapeake Care Nursing Home Arnold 8. Date of Birth (Month, Day, Year) 1, 1913 Birthplaca (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2/2 F 86 577-01-5545 Yrs Director Washington DC Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Arnold MD Anne Arundel 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 21012 IISA 286 College Manor Drive death Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Stetus Pages 1 and 2 should be filed within 72 hours effer nent of Heelth end Mentel Hygiene. 1 Yas 2010 If Yes, Give Yaar or Dates: 1 Never Merried 2 Married natural, or Baltimore, Maryland 21215-0020 White 1 Yes 2XNo Specify: Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Collega (1-4or 5+) Education Teacher 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 27 is marked of Albert Benjamin Brown Iva Mae Beall 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e, Informent's Neme/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Heelth er Important: If flem 27 is any injury or other trau once. Kathy Towers (Daughter-in-law) 286 College Manor Drive, Arnold, MD 21012 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete 1

Buriel 2 □ Cremation 3 □ Removal from State 01/03/ Cedar Hill Cemetery Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name end Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner The lew requires that the deeth certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In deeth) Last Due to (or es a consequence of) end P.O. Box 68760, Physician/Medical Due to (or es a consequence of): 88 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. λq been signe should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? After 1 Netural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 6 Could not be within 24 hours after dea To the Funeral Director completely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) ş 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D21684

DHMH 16 Ray 6/95

State Registrar

YRIAC.M.D

31. Data filed (Month, Day, Year)

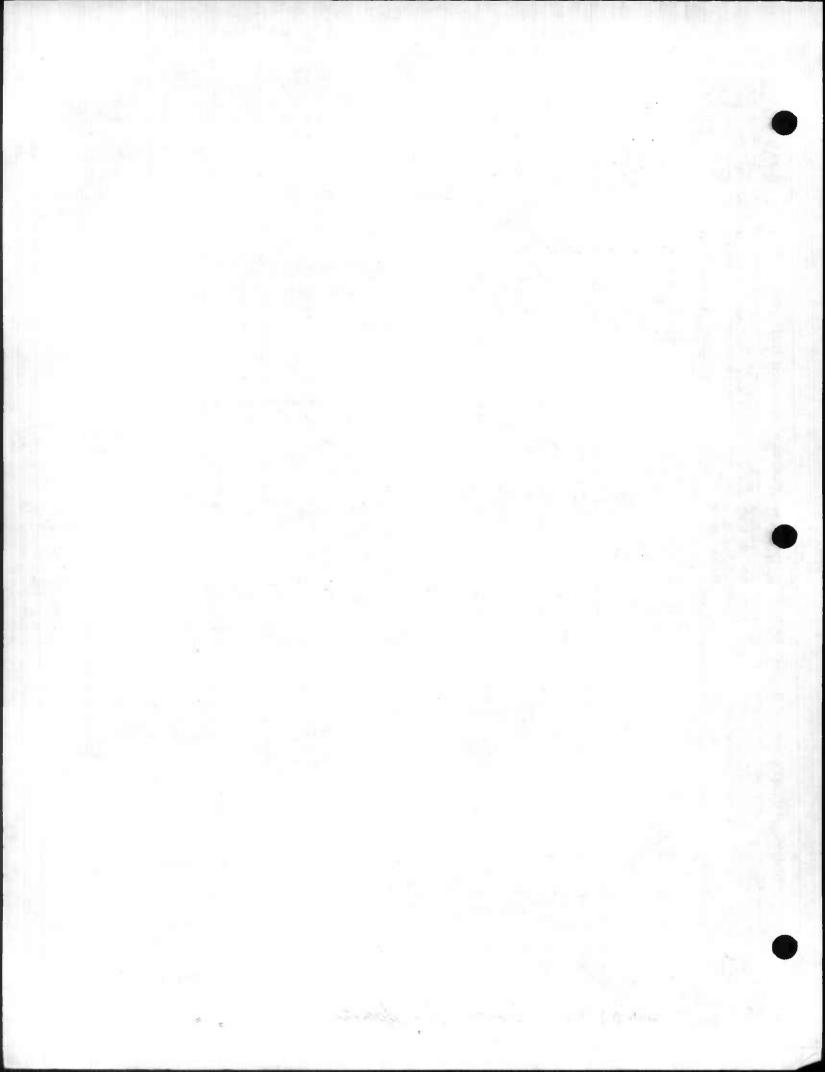
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32. Registrar's Signature

RITCHIE HUY.

PASADENA, MD 21122



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item#1 perPhyG780 2/22/2000 EwState of Maryland / Department of Health and Mental Hygiene Q AMEND ITEM: #5 PER F.H. G780 2-17-2000 WR. Certificate of Death 2. Date of Death Month 1. Decedent's Nama (First, Middle, Last) 3. Time of Death Day Year **Physician** Daisy DEC. 1999 9:20pm 30 JUANITA THOMPSON /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HARFORD HARFORD MEMORIAL HOSPITAL HAVRE DE GRACE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1□ M 2€34 Months 215-32-602624 62 Yrs. Director JAN 10 1937 VIRGINIA Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yes 2 No Director ABERDEEN MARYLAND HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21001 U.S.A. 199 DARLINGTON AVENUE 238 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces?

1 Yas 2 XXX0 14. Race - American Indian, 11. Marital Status Black, White, etc. the Medical Examiner 1 Never Married 2 X Married ò 1 Yes 2 X No Specify: If Yas, Giva Specify: BLACK P 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry ifiled within 7 I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) pemit. Pages 1 and 2 should be filled w
Department of Health and Mental Hygien
important: if Item 27 Is marked other th
any Injury or other traumette accept HOUSEWIFE DOMESTIC 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) SAMUEL AMES ELSIE WILLIS AMES 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 199 Darlington AVenue, Aberdeen, Maryland 21001 GEORGE E. THOMPSON/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Murial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST 1-6-00 OWINGS MILLS, MARYLAND 21. Signature of Funeral Service Limit 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME-ABERDEEN rown 321 S. PHILADELPHIA BLVD., ABERDEEN MD 21001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner RUNONIA Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence ot): Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel; Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1. Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 27. Many fer of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending Natural 5 Pending 1 Yes 2 No investigation 2 Accident after death Director: 6 Could not be determined 3 Suicida 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide ò

within 24 hours of the Funeral D

Registrar

DHMH 16 Rav 6/95

edical

29a. Certifier (Check only one

29b. Signature and title of certifier

4

non who completed cause of death (Item 23a) (Type, Print)

MNOH Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainten as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year)

W AWA

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1) Certificate of Death Amended Item#19b perFH G779 1/4/2000 EW 1. Decedant's Neme (First, Middla, Last) 2. Data of Deeth 3. Time of Death Pm Month 78 Hay 1999 IROCKI EIR DECEMBER 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, giva street and number) NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Undar 24 Hrs. 8. Data of Birth (Month, Day, Yaer) If Undar 1 Year 5. Social Security Number Birthplaca (Stata or Foraign Country) 6 Sex 7. Aga (In vrs. last birthday) 1 M 2 F Months Days 88 15, 1911 POLAND 214-38-2940 Usuel Residance of Dacedant 10d. Insida City Limits 10b. County 10c. City. Town or Location 1 Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4269 LABYRINTH RD. 21215 IISA 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yas, Giva Yeer or Datas: 14. Race - Amarican Indien, Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Ricen, atc.) 11. Marital Status Black, Whita, atc. 1 ☐ Navar Marriad 2 ☐ Married 1 Yas 2 No Specify: Specify: WHITE X□ Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedent's Education (Spacify only highast grada complated) Elamentary/Secondary (0-12) College (1-4or 5+) 9 YEARS TAILOR GARMENT 18 Mother's Nama (First Middle Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) (UNKNOWN) (UNKNOWN) **DOBRUSHA** 19b. Mailing Addrass (Straat end Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) MARTIN TROCKI (SON) 11120 ROKEBY AVE. GARRETT PARK, MD 20986-20896 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 12/30/99 1X Burial 2 ☐ Cramation 3 ☐ Ramoval from State SHOMREI MISHMERES SCHARES HAPLATA ROSEDALE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama end Address of Fscility 21. Signature of Eunaral Service Licensas SOL LEVINSON & BROS., INC. PIKESVILLE, MD 21208 8900 REISTERSTOWN RD. c 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onsat and Death Immediata Causa (Final diseese or condition rasulting in death) PHEUMUNIA . ASPIRATION 15 DAYS Due to (or es e consequence of): PARKINSUM'S DISEASE Sequantielly list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Diseasa or injury that initieted events rasulting in daath) Last Dua to (or as a consequence of): YEARS. DEMENTIA Dua to (or as e consequence of) 23b. Dtd tobacco use contributa to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yas 2 ☐ No 24b. Wara autopsy findings available prior to 24a. Was an autopsy performad? complation of cause of death? 2 No 1 ☐ Yas 2 ☐ No

Physician /Medical Examiner

Physician

/Medical

10a Stata

Director

Funeral

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Completed

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Marylend Depentment of Haaith and Mental Hygiena. Important: If Item 27 is marked other than "naturel", or frems 23s or 28s-f show any injury or other treumstic event, the Medical Evantment than bottled at

Baltimore, Maryland 21215-0020

Examiner physicien and the burief-transit The law requires that the death certificete be executed Physician/Medical signed by the a by been sig Completed certificate has b director Be Certification: To this

Division of Vital Records, P.O. Box 68760 or Attending Physician: funeral After death. after death Director: / within 24 hours aft To the Funeral Dis completaly filled in

State Registrar

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31. Data filad (Month, Dey, Year)

25. Was cesa rafarrad to medicel examiner? 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) 1 Yas 2 No 1 Dipatiant 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28d. Describe how Injury occurred 28a. Data of Injury (Month, Dey Year) 28b. Tima of 28c. Injury et Work? 5 Pending invastigation 1 Neturel 1 Yas 2 No 2 Accidant 6 Could not be determined 3 Suicida 28a. Place of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 28f. Location (Street and Numbar or Rurel Routa Number, City or Town, Stete) 4 Homicida 29a. Cartifian 📆 Certifying Physician: To the best of my knowledge, death occurred at the tima, date end place, and dua to tha causa(s) and manner as stated. (Check only one) 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

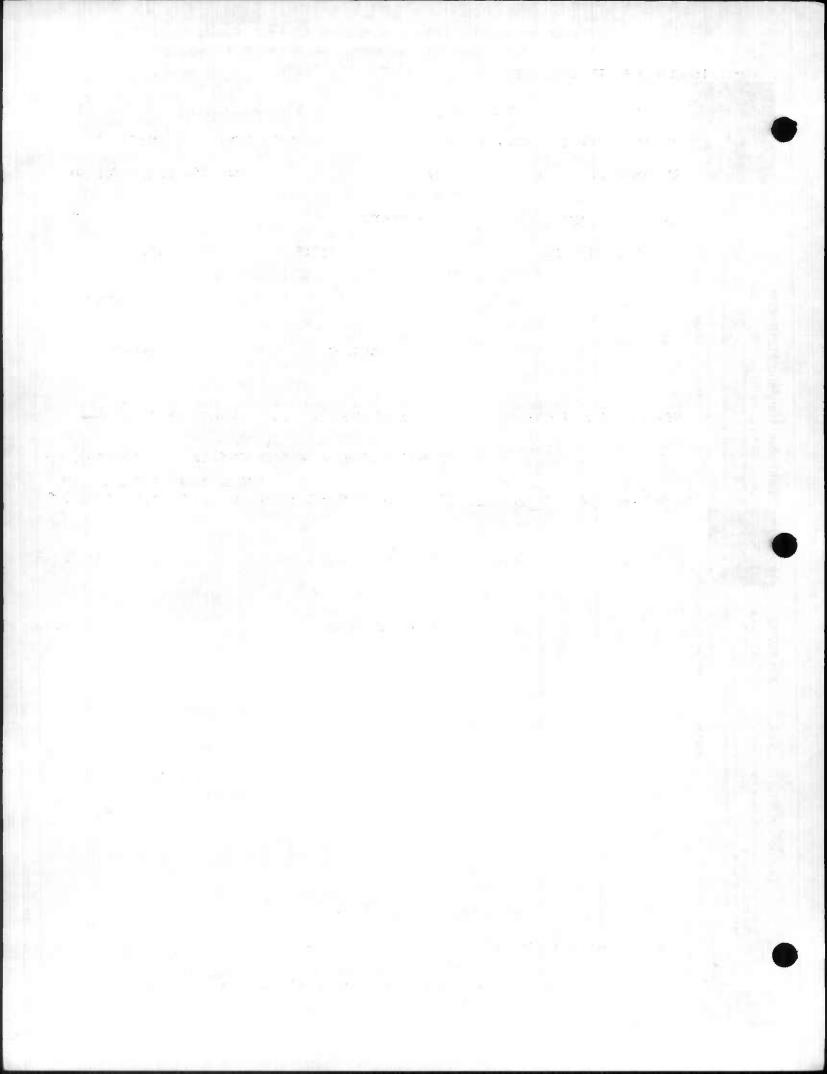
29d. Data signed (Month, Dev. Year)

milta. m.o 41410

30. Nama and address of person who completed cause of daath (Itam 23a) (Type, Print) MUSPITAL MORTHWEST

JOGINDER P MEHTA RAMDALISTOWN MO 21133

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

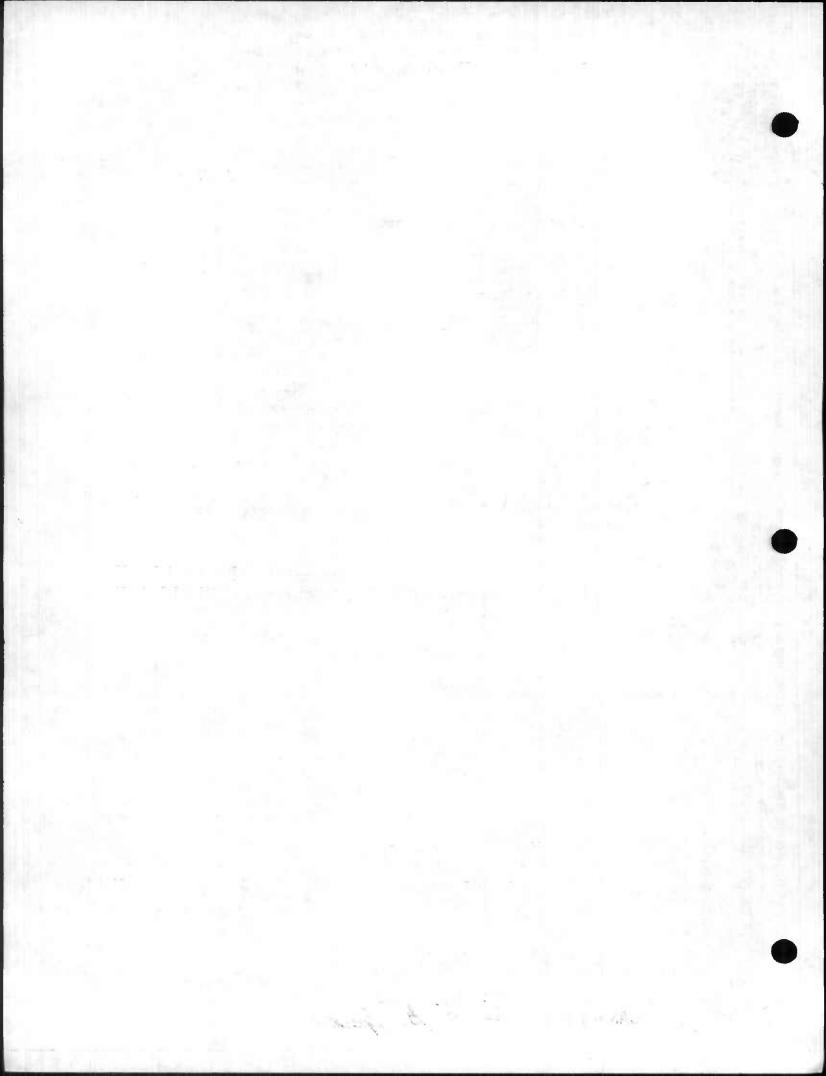
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WILLIAM WELLS AMEND#23B,27&28a-f PER M.E. G779 1-11-2000 ificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** William Vernon Wells 1999 DEC. 29, 12:27 PM /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner 415 NORTH BEND ROAD APT. H BALTIMORE Baltimore If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Deys Hours 10M 20F Yrs. 212-52-2527 41 12/23/1958 Director Md Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 26a-f show notified at 1 ☐ Yes 2 ☐ No Directo Baltimore Baltimore 96 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 415 North Bend Drive Apt H USA 21228 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Meritel Stetus filed within 72 hours after 1 Yes 2 No If Yes, Give X Year or Detes: 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 b 1 ☐ Yes 2 ☐ No Specify ğ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Hygiene. 12 Agent Insurance 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Pages 1 and 2 should be nent of Health and Mental Harthel R. Wells Margaret Ann Mosberg 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 Harthel R. Wells/father 2001 Helmsby Rd, Catonsville, Md. 21228 20b. Piece of Disposition (Neme of cemetery, cremetory or other piece) 20a Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Suriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Woodlawn Cemetery 01/04 Baltimore, Md. ure of Funeral Service Licensee 22. Neme end Address of Fecility Sterling-Ashton-Schwab Funeral Home, Inc 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Approximate** Intervel Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical RUPTURE ASSOCIATED WITH Examiner ANEURYSM ACUTE COCAINE INTOXICATION Examiner use as the burial-trensit The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest Box 68760, Physician/Medical Due to (or es e consequence of) P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown of Vital Records, þ 24b. Were eutopsy findings evailable prior fo completion of cause of deeth? 24e. Wes en autopsy performed? Be Completed page 2 1 XYes 2 □ No 1 XYes 2□ No or Attanding Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel; 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28a. Dete of Injury (Month, Day Year) | 28b. Time of p | 2 Injury | FOUND 12-29-99 | FOUND AT12.10 27. Menner of Death 28c. Injury et Work? 28d. Describe how injury occurred After Division 1 Accident 5 Pending investigation after death.

I Diractor: Aft od in by the fu 1 Yes UNKNOWN 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 6XXCould not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI FOUND AT HOME. 415 N. BEN ROAD BALTIMORE, MD. 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29d. Date signed (Month, Dey, Yeer) 29b. Signeture end little of certifier 29c. License number O.C.M.E DEC. 30, 1999 30. Neme and address of person who c leted cause of death (Item 23a) (Type, Prinf) 111 Penn Street, Baltimore, Maryland 21201 huten emis 31. Dete filed (Month, Dey, Year) 32. Pogistrer's Signeture State JAN 04 2000 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day December 28 1999 10:05PM Wilder Eloise Η. 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Pickersgill Towson If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth 9. March Day Year) 1904 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 4 New Jerse 1□M 2□F Months Hours 95 143-40-3055 Jersev Usuel Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Towson MD. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 615 Chestnut Ave. USA 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Maritel Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Clerical Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hollers Charles Hulphers Agnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7624 Club Rd. Ruxton, MD. 21204 Mr. Richard Wilder/Son 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2√☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Co. 12-30-99 Towson, MD. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of Funeral Service Licanus Inc. 21204 23a. Pert1. Enter the disease of contribution that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one citize on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disaasa or condition rasulting In death) e u monit Dua to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yas 2 No 25. Was casa raferred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: A Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide

physician and the burial-transit The law requires that the death cartificate be axecuted Box 68760, P.O. Division of Vital Records, or Attending Physicien: this Aftar n 24 hours after death.

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Physician

/Medical

Examiner

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by Funeral

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7 is marked other than "natural", or fema 23a or 28a-f ahow traumatic event, the Medical Examinar must be notified at

permit. Pagas 1 and 2 should be filed within 72 hours aftar to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or itel important: if Item 27 is marked other than "naturel", or itel eny injury or other traumatic event, the Medical Examine page.

Physician /Medical

Examiner

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Certification: To

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Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Year)

JAN 0 4 2000

29b. Signeture and title of confile

(Check only one)

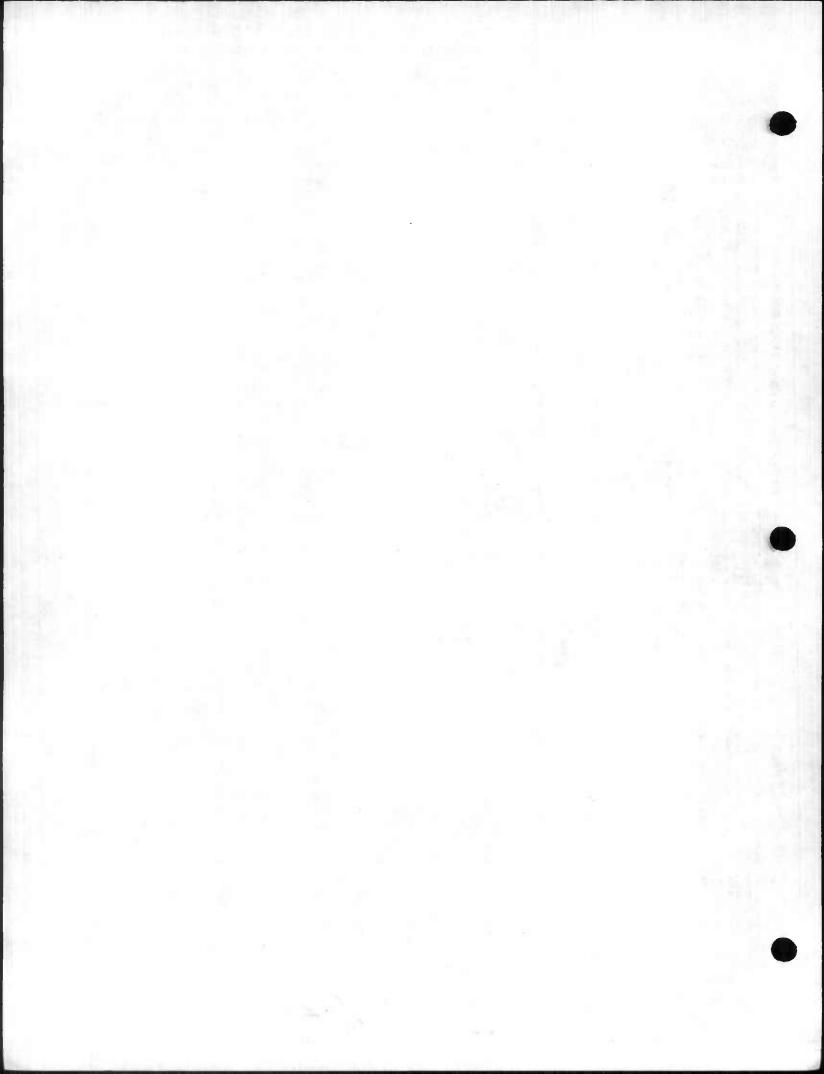
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GBMC 6701 32. Registrar's Signature

N. Charles St. Baltimon, 1918

12 certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

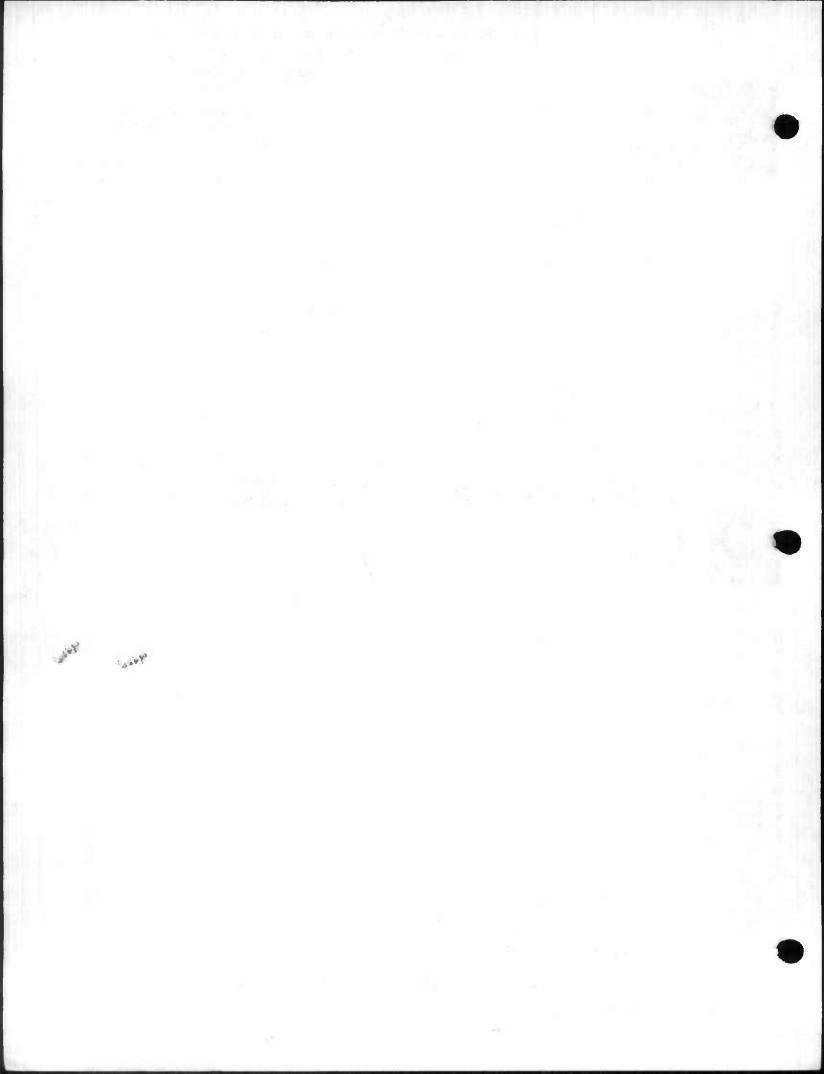
29c. License number

29d. Data signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 4 528

						C	ertificate	e of	Death		Reg. No.	0	0 8	1 kg ()
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Т	Funeral	Г	5. Social Security Number	6. Sex	7. Age (In yi	s. last birthda			If Under 24 Hrs.	8 Date of Bi	rth Vanal	9. Birthp	lace (St	ate or Foreign
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	or 28	Director	10e. Street end Number				10f. Zip	Code			10g. Citizen of	Whet Coun	ntry?	
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Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Wil John Jec 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mary Baltimore land Universit 0 n/a If Under 24 Hrs. If Under 1 Year 7. Age (In yrs last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) Months 101M 20 F 543-12-5537 June 25 1915 Oregon Usual Residence of Deceden 10a. Stete 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Anne Arundel Co. Pasadena 10a, Street and Number 10f. Zio Code 10a. Citizen of What Country? 8254 Spring Knoll Drive 21122 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 No 1 ☐ Yes 2 No Specify: Specify: white 3 AWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Automobile Co. Mechanic 8 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry C. Wilcox Beatrice Huff 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8254 Spring Knoll Drive Pasadena, Md. 21122 Jennie J. Helwig (Friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Cemetery 12/27/99 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. 21122 Approximate interval Between Onset and Death Immediate Cause (Final Mulbiorgan system disease or condition resulting in deeth) Pulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last oaquio Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes & No 1 Yes 2 No 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: 1 Yes \2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. injury at Work? Natural 5 Pending investigation 1 Yes 2 No 2 Accident

P.O. Box 68760, Division of Vital Records,

 Hospital or Attending Physician: The law requires that the death certificate be executed
 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending characterism and the burial-transit attending physician for use as the burla been signed by the a should be detached pege 2 director, Certification: To funeral To the Hospital or Attendin within 24 hours after death. To the Funeral Director: At completely filled in by the fu

Physician

/Medical

Examiner

Funeral

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Name 23a or 28a-f show

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Pages 1 and 2 should be filed within 72 hours after

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Department of Health as Important: if Item 27 is any injury or other trau

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the Medical Examiner must be notified at

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Medical State Registrar

DHMH 16 Rev 6/95

Timonthy F. Nodurf 31. Dete filed (Month, Day, Year) JAN 0 4 2000

29b. Signature and title of certifier

3 Suicide

29a. Certifier (Check only one)

4 Homicide

6 Could not be determined

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

22 S. Greene Street, Baltimore, Md. 21201

To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

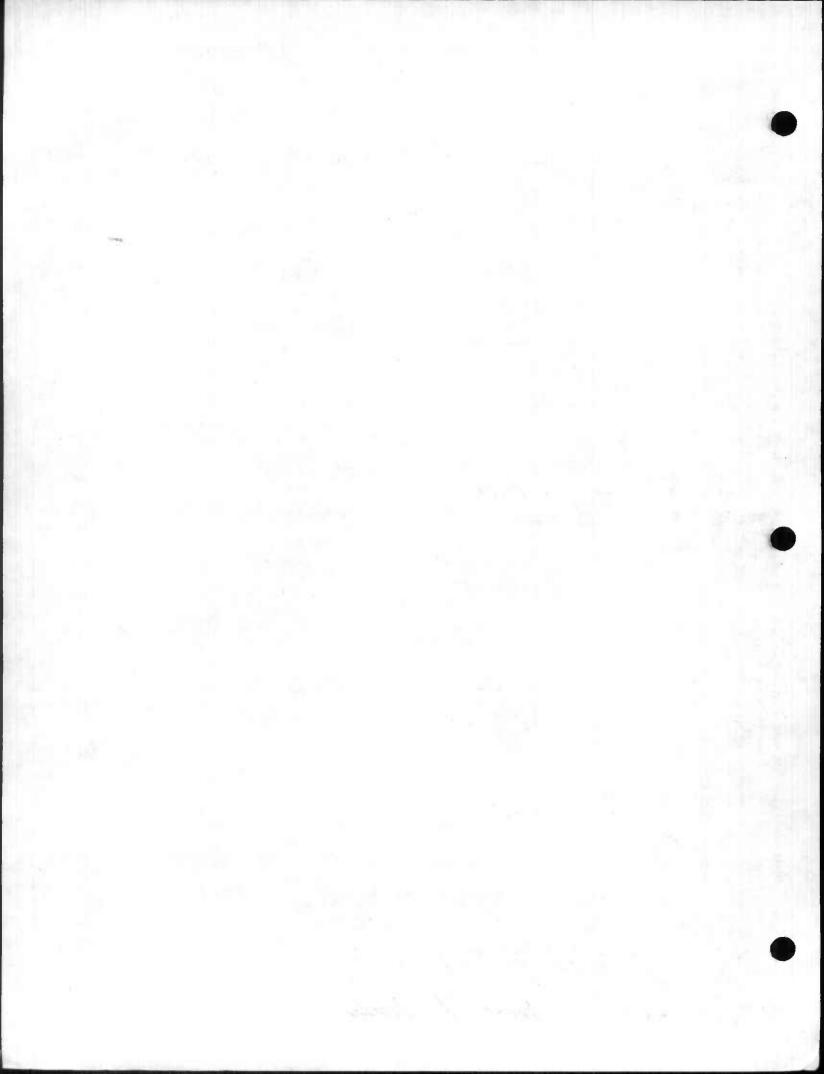
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

10032

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					State of W	ai yiai				Death	wiernar rry	Reg. No.	99	41530	
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020	L'.	by Funeral	11. Marital Status 1 Never Marrie 3 Widowed 4		12. Was Decedent Armed Forces? 1. Yes 2 If Yes, Give Year or Dates:	No 11	-21-42		edent of H ecify Cubi 2 No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or Note Rican, etc.)		ce · America ck, White, e y: White	etc.	
21215-0020	within 72 hours ene. than "natural", na Wedical Ex	Completed	(Specif	15. Decedent's Ed y only highest gra dary (0-12)		5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Trucker 16b. Kind of Bus								
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	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If Itam 27 is marked other than or other traumatic avent, the 14		19e. Informent's Name/Relationship (Type, Print) Step-daughter / Joan Reynard 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1817 Selma Ave. Arbutus, MD. 21227 Oa. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State)												
Baltimore,	Pages 1 nant of He ant: If Itam ary or oth		beep dadginess / Joan Reynard												
Bait	permit. Page Department of Important: If any Injury or once.		21. Signature of Fund	eral Service Licen	nicy	14 4	/ Ami	bros	e Fu	ss of Facility neral Ho er Sprin			MD	21227	
	-		23a. Pert1. Enter the shock, or heart	disease, or completely disease,	lications that caused one cause on each li	the deat	Do not ente	r the mo	de of dyin	ig, such as cardia	c or respiratory	arrest,	, 115.	Approximate Interval Between Onset and Death	
	Physician /Medical Examiner		disease or condition	Immediate Cause (Finel disease or condition resulting in death) a. MYUCANDIAC INFANCTION Due to (or as a consequence of): CONSIGANT ANGLY DISEASE YEARS											
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90,	olan a		Sequentially list conditions, leading to immoduse. Enter Underlicause (Disease or in	nediate ying ijury	HEN	1							6	1 CARS	
68760,	ficate be executed physician and as the burlai-transit	BOICE	that initiated events resulting in death) La		6	Due to (o	r es a consequ	ence of)	:				1		
Box (o. Renep	2	inf	sul	CP1	ence	7		2	jans	
	0 0 2 7	rnysicianym	Part II. Other signific	ant conditions co	ntributing to death b	ut not res	ulting in the un	derlying	cause giv	en in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death?	
s, P.O	£ 60 .	Dy ruy									1 🗆	Yes 2□ No	3 Prot	bebly 400nknown	
Vital Records,	a law requires has been sign ge 2 should be	Completed									24a. Was peri	s en autopsy ormed?	SIVE	ere autopsy findings allable prior to mpletion of cause death?	
<u>=</u>	The in	5									10	Yes 2 XXIII	1 🗆	Yes 2□ No	
VIIt	9 gg a		25. Was case referre examiner?		Hospital:				Oth Oth	or	ath (Check only				
of	this did	- 1	1 Yes 2501 27. Manner of Death	0	28a. Date of Inju	ry	ER/Outpatient 28b. Time of		OA Our 28c. Injur Wor	4 LI Nursing I	7	how injury occur		()	
ion	Attending Ph or death. actor: After th by the funeral	STIC	Natural 2 Accident	5 Pending investigation	(Month, De	y Year)	Injury	м		k? Yes 2 ☐ No					
Division	or At Affer of Direct in by		3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)							office 28f. Location (Street and Number or Rural Route Number, City or Town, Stete)					
	To the Hospital Within 24 hours at To the Funeral I completely filled	8215	29a. Certifier (Check only	Certifying Phy Medical Exam	reician: To the best of the basis of and manner sto	examina	wiedge, death tion and/or inve	occurred	at the tin	ne, date end place pinion, death occ	e, and due to the urred et the time,	cause(s) and m , date end place,	anner as st and due to	ated. the cause(s)	
	Vithin Vompi	-	29b. Signature and	te of certifies				29	c. Licens	e number		29d. Date signe	d (Month, i	Day, Year)	
			1 /2	00112	2			AL	141-	76435	C10001	pecen	nber	-31,1999	
	10	1	30. Name and addres	s of person who o	ompleted cause of d	eath (iten	23a) (Type, P	rint)			900	South	Cator	n Ave	
	W.		31. Date filed (Month,	OSEPO	4 Jon	m	(10	10	4	MO	Balti	more,	MD.	21229	
	State Registrar			Day, rear) ΔΝαλοι	32. Registr	m s Sign8	~ 4	- 1	100	1					

DHMH 16 Rev 6/95

J-10/8/HAV Jamon B

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 150 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** GEORGE N. WIRTANEN 31,1999 07:25 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** VA MARYLAND HEALTH CARE SYSTEM FORT HOWARD BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex. 1 → M 2 → F 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 094-10-9164 Director WISCONSIN Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location rail, or items 23s or 28s-f show Examiner must be notified at 10d. Inside City Limits Baltimore County Maryland Baltimore 1 ☐ Yes XX No Directo 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? with 21234 USA 2614 Hillcrest Avenue death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give J.W 11 Year or Date. W Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married "natural", or 1 ☐ Yes XX No Specify: Specify: þ X Widowed 4 □ Divorced White Completed Decedent's Usual Occupation
 (Giva kind of work done during most of working life. DO NOT use retired) The Medical 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Businass/Industry Pages 1 and 2 should be filed within Elemantary/Secondary (0-12) Collega (1-4or 5+) Self-Employed 12 yrs. 2 yrs. Painter traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Niilo Wirtanen Rosa Rautinen 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9 Department of Health of Important: If Nem 27 Is any Injury or other trapped. Mrs. Regina W. Baker 5623 Tramore R. Baltimore, Md. 21214 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☼ Cremation 3 ☐ Removal from State Metro Crematory Inc. 12-31-1999 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Lassahn Funeral Home West 7401 Belair Rd. Baltimore, Maryland 21236 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition resulting in death) /Medical BRAIN TUMOR (GLIOBLASTOMA MULTIFORME 2 months Examiner Due to (or as a consequence of): Examiner icien end bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien s the burial Physician/Medical Due to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s 1 Yas 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Was case rafarred to medical examiner? 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 XInpatiant 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 1 Yes 2 No deeth. Investigation 2 Accident within 24 hours after deel To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, atc. (Specify) 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicida Hospital 29a. Certifier edical 1 Certifying Physician: To tha best of my knowledge, death occurred at the tima, date and place, and dua to tha causa(s) and mannar as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. (Check only one) ş 29d. Date signed (Month, Day, Year) 29b. Signature and title of certitier 29c. License number DEC 31, 199 0 march 30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print)

State Registrar

JAN 0 4 2000

GALICIA, MD

31. Date tiled (Month, Day, Year)

32. Régistrar's Signature

9600 NORTH POINT ROAD, FORT HOWARD, MD 21052

DHMH 16 Rev 6/95

Baitimore, Maryland

Box 68760.

P.O.

Records,

Division of Vital

JAN DECEMBER OF THE SERVER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Day Month **Physician** Genevieve Anspacher December - 12, 1999 4c. County of Death /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington | H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | Min. | July 19, 1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 10 M 29 F Maryland 215-18-2434 Director Usual Residence of Decedant t Oa. Stata t0b. County 10c. City. Town or Location t0d Inside City Limits 28a-f show Maryland Washington Hagerstown Y Yes 2 No Director the tile Street and Number 10f. Zip Code t0g. Citizen of What Country? ò 26½ E. Franklin Street 21740 USA Herns 23s Funerai 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? t 4. Race - Amarican Indian, Black Whita atc. should be filed within 72 hours after ond Mental Hygiene.
marked other than "natural", or he 1 ☐ Yas 2 No If Yes, Giva 1 ☐ Nevar Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: by 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) t5. Decedent's Education (Specify only highest grade completed) t 6b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Housewife Home permit. Peges 1 and 2 should be file.
Department of Health and Mental Hygh
Important: if Item 27 is marked any Injury or other to 18. Mother's Nama (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middle, Last) Be Russell Floyd Cromer Edna Mae Dofflemeyer 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) t9a. Informent's Neme/Reletionship (Type, Print) Maryland 21740 9 Public Square Hagerstown, Charlene K. Lloyd 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cremetion 3 ☐ Ramovel from Stata 12/14/99 Rest Haven Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) hagerstown, Maryland 21. Signature of Funarel Sarvice Licenses Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediata Cause (Final ATHEROSCIEROTIC CARIDIO VASCULAR DISEASE

Due to (or as a consequence of): disaasa or condition rasulting in death) Examiner Examiner CEREBRO VASCULAR aCCIDENT 94 45 Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting In death) Last Due to (or as a consequence of) P.O. Box 68760. DEMENTA Physician/Medicai Dua to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 nknown 1 Yaa 2 No signed I Records, p 24b. Wera autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy performed? t ☐ Yes 26 No 1 Yas 2 No Division of Vital 25. Was case referred to medical axaminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) t□ Yas 25 No Medical Certification: To t ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred Hospital or Attending Pl
 24 hours after deeth.
 Funeral Director: After th 28b. Time of 28c. Injury at Work? After t DiNatural 2 Accident 5 Pending 1 Yas 2 No investigetion 6 Could not be 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and dua to the causa(s) and manner stated. 29a. Cartifiar 29d. Data signed (Month, Day, Year) 29b. Signatura end title of certifie 29c. License number Mausen 12.13.99 D2836 5 30. Nama and addrass of person who complated cause of death (Item 23a) (Type, Print) SHATT HAGERSTOWN MAD MAN2AR 368 MILL ST 1999 Registrar's Signature 3t. Dete filed (Month, Day, Year) State DEC 1 Registrar

DHMH 16 Ray 6/95

Nspacher, Genievieve





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December 11,1999 4:30 PM John Augustowski Chester /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Frederick Memorial Hospital Frederick

| If Under 24 Hrs. Frederick If Under 1 Year 8. Date of Birth (Month, Day, Year) July 12, 1928 Birthplace (State or Foreign Country)
 New York 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1**X** M 2□ F 103-22-3375 71 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23a or 28a-1 ahow the Medical Exampler must be notified at 1 Yes 2 No Director West Virginia Berkeley Falling Waters 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1012 Ambler Lane 25419 USA deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No 1946— If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritel Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mentai Hygiene. Important: if flem 27 is marked other than "natural," or her apply injury or other traumatic event, the Mentain of the page. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify Specify: White P 3 Widowed 4 Divorced Yeer or Detes 1949 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Shipping Foreman Box Manufacturer 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Augustowski Agatha Dybas 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Marion E. Augustowski/Wife 1012 Ambler Lane Falling Waters, WV 25419 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory Dec. 12,1999 Smithsburg, Maryland 21. Signeture of Funeral Service Licenses 22. Name and Address of Facility 425 S.Conococheague St. Williamsport,MD 21795 Osborne Funeral Home 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Fine) hematona Subdur-1 disease or condition resulting in deeth) Examiner Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. the signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown M hal value my low by 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen estime heart failure 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) After this funeral 27. Manner of Death 1 PNaturel 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After ti completely filled in by the funera 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29e. Certifie (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier

State Registrar

Dennis Winters, M.D. 198 Thomas Johnson Drive #6 Frederick, MD 21702 31. Date filed (Month, Day, Year) 32. Registrer's Signature 5 1999 DEC 1

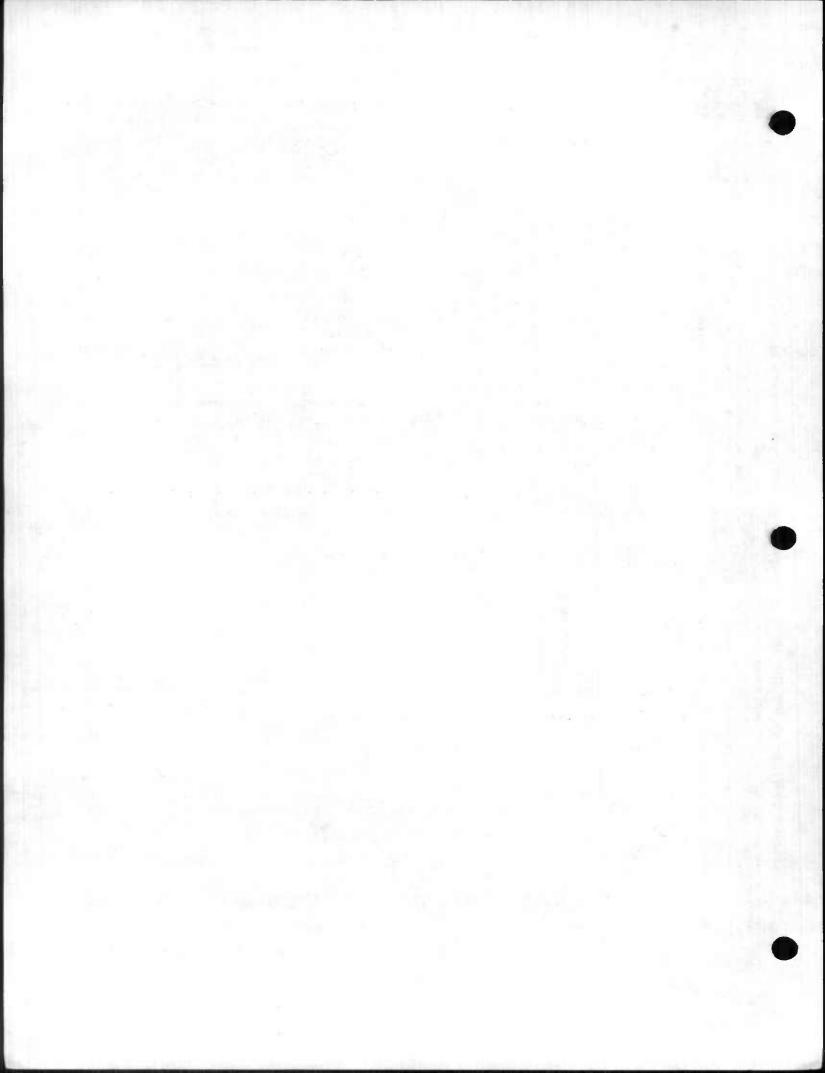
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

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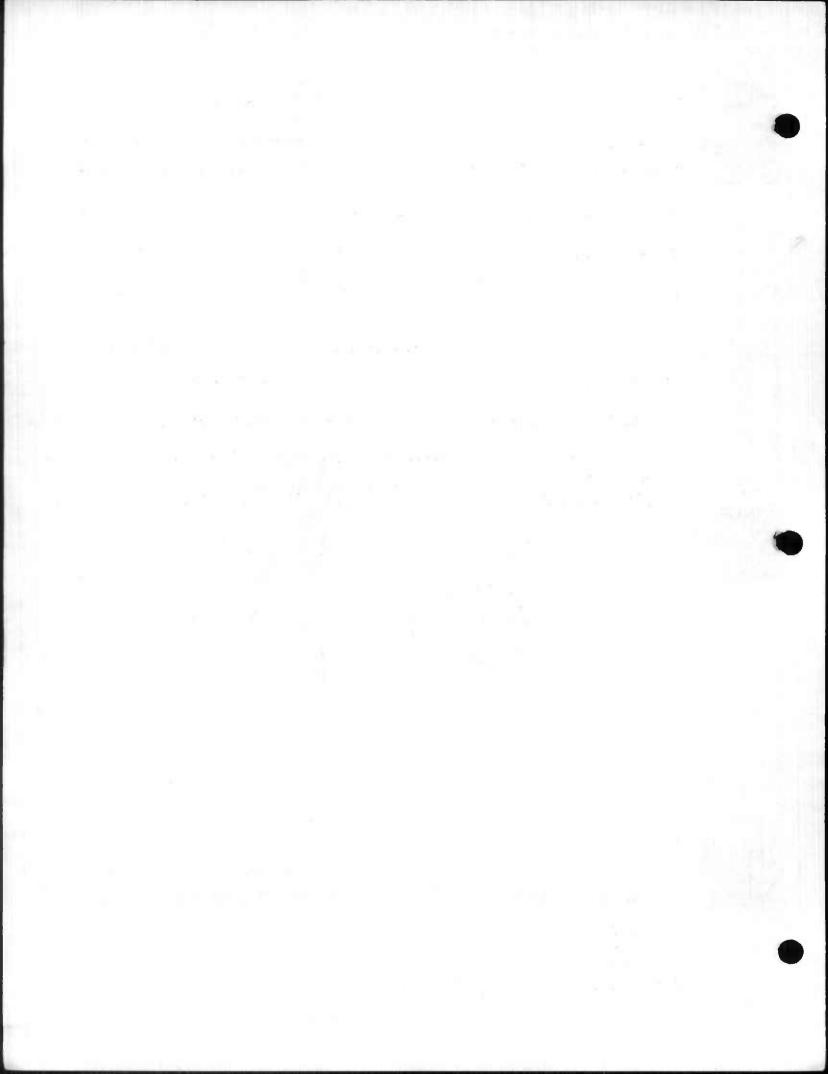


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State of Maryland / Department of Health and Mental Hygiene 00

				-	Certificate of			g. No.	41534				
Physic	ian	1. Decedent's Name (First, Middle, Las	•				2. Dete of Deeth Month		3. Time of Death				
/Medi		Violet Elizab		rton			December						
Exami	ner	4e. Fecility Neme (If not institution, give	street end number)			4b. City, Town, or I		4c. County of De					
		Mallard Bay (5. Social Security Number 6. Se	Center	e (In yrs. last birt	hday) If Under 1 Year	Cambrio			chester				
Funerai Director		The state of the s	7 7 7 7 7 7		rs. Months Deys			1916	Birthplece (Stete or Foreign Country) Maryland				
1 8 8 1		10a. State 10b. County		10c. City, Towr	or Location				10d. Inside City Limits				
The Mary	ctor	Maryland Dorches	ster	C	ambridge				1 XXes 2 □ No				
23a or 21	Funeral Director	10e. Street end Number 701 Race Street			10f. Zip Code 216	513	10	g. Citizen of Whet	Country?				
1020 Cours after do:	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married XX Wildowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes XIX N If Yes, Give Year or Detes:	Ever in U,S. No	13. Wes Decedent of If Yes, specify Cut 1 ☐ Yes ※※ No		pecify Yes or No- o Ricen, etc.)	14. Race - Ar Black, W Specify:					
21215-0020 d within 72 hours at gisns. r than "natural", or the Medical Exam	Completed	15. Decedent's Edu (Specify only highest gred Elementary/Secondary (0-12)	ucetion le completed) College (1-4or 5	+)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire rab Picker	pation during most of wor ed)	rking 1	6b. Kind of Busines	·				
D EL	S	17. Fether's Neme (First, Middle, Last)			lab lickel	18. Mother's Nan	me (First, Middle, M		ou				
d be d be serial	o Be	Wilbur Lewis					a Elizabe	,	rs				
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event,	10	19a. Informent's Name/Relationship (T)	ype, Print)	19b.	Mailing Address (Stree	t end Number or Ru	rel Route Number,	City or Town, Stete	a, Zip Code)				
		Jean S. Thomas	Daughter						yland 21613				
Baltimore, semit, Pages 1 a Separtment of Hos mportant, if Nem iny Injury or othe IGGs.		20a. Method of Disposition 1778uriel 2 Cremation 3 F	Removal from State	20b. Plece of cemeter	Disposition (Name of r, cremetory or other ple	ece)	Dete 2	Oc. Location - City					
Saltir imit. P spartme sportari vy injuri isse.		4 Donation 5 □ Other (Specify) 21. Signature of Funeral Socycle Licens		DOI CHE	22. Name end Addr	ess of Fecility		Campringe	e, maryiand				
00 82558		Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613											
Physician		23e. Pall Enter the diseese, or comp short, or heart failure. List only o			ot enter the mode of dy	ing, such es cerdiac	or respiretory erre	st,	Approximete Intervel Between Onset end Deeth				
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Conqu	estic	e her	il fo	ailu eccid disea		Jea.				
pe sist	Examiner		Cerel	non	aseul	an t	eccid	lend	year				
6 execution and inial-tran	i Exar	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initieted events	Loud	Due to (or es e o	onsequence of):	ery "	sc.	year.					
68760, tilicate be executed g physicien and es the bunal-transit	fedical	ceuse (Disease of Injury that indited events resulting in deeth) Lest		Due to (or es e g	nsequence of):								
O. Box ne death cert the attendin	an/Ne		d. DIOC		7,000	Level 1-1							
deat deat	sicia	Pert II. Other significent conditions con	ntributing to death bu	ut not resulting in	the underlying ceuse g	iven in Pert I.	23b. Did tot	acco uee contribu	ute to the causa of death?				
d by	y Physician/N						1 □ Ye	Yes 2 No 3 Probably 4 Unknow					
Vital Records, P.O. Box siden: The law requires that the death cer certificate has been signed by the attendinitietor, page 2 should be deteched for use	Completed by						24a. Wes en perform	eutopsy 24 ed?	b. Were eutopsy findings evelleble prior to completion of cause of deeth?				
Vital Rec sician: The law s certificete hes b director, page 2 si	E O						1 □ Ye	s 2 1 No	1 ☐ Yes 2 Ø No				
Ita	Be (25. Was case referred to medical examiner?				26. Plece of Dea	ath (Check only one)					
Of V Physic rthis ce ral dire	2	1 Yes 2 No	Hospital: 1 Inpatie		petient 3 DOA Ot	her: 4 Nursing H	lome 5□ Resider	nce 6 Other (S	pecify)				
DIVISION Of VIta to Attending Physician: after death. Director: After this certification by the funeral director.	ation:	27. Manner of Deeth 1 Neturel 5 Pending investigation	28e. Dete of Injur (Month, Day	y Yeer) 28b. T	jury Wo	nyan ork?]Yes 2∐No	28d. Describe how	w injury occurred					
DIVIS I or Atte after de I Directo	ertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Inju- building, etc	ury - At home, fai :. (Specify)	m, street, fectory, office	fice 28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical Certification:	29a. Certifier Certifying Phy.	sicien: To the best of ner: On the basis of end menner sta	examinetion end	deeth occurred et the ti	ime, date end plece opinion, death occu	o, end due to the centred et the time, de	use(s) end menner te end plece, end c	es steted. due to the ceuse(s)				
o the	Me	29b. Signeture english of certifier				se number		d. Date signed (Mo					
->-0) E ~	7		Typa, Print) Arrora B. Span	0987	1						
Ti .		30. Neme and address of person who co	ompleted ceuse of de	eeth (Item 23e) (Type, Print)	Nin	To Can	nbro	ge mo				
		Amnes V	awas	300	murora				0 21613				
Sta Regist		31. Date filed (Month, Day, Year) DEC 1 7 19	999	r's Signature	G. Space	KN			7				

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11:05 AN Patricia Jane Boward December 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 ☐ M 2 🛱 F 69 Yrs. 215-26-1706 March 5, 1930 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington Co. Hagerstown tolyes 2 □ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 475 McDowell Avenue 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 1 Yes 2√2 No Specify: Specify: White 3 ₩idowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Shoe Factory Laborer 10 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Howell McElroy Alcie Theresa Mays 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah A. Kline/Daughter 17420 Garden View Road, Hagerstown, Maryland 21740 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State tery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State Rose Hill Cemetery Hagerstown, Maryland Dec.18 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 21. Signature of Funeral Service Licenses unmernen 23a. Part1. Inter the glease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of neumon(COM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobgeco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown Wmany 1 Cocabol 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2000 1 □ Yes 2 □ No 1 ☐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mennes of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Examiner physician and s the burial-trensit The law requires that the death certificate be executed P.O. Box 68760, Physician/Medical should be det Records. Completed by page 2 a Division of Vital Physician: funeral director, Be Medical Certification: To After this or Attending 24 hours after death.

Funeral Director: A filled in by Hospital

Physician

/Medical

Examiner

Director

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Baltimore, Maryland

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Pages 1 and 2 should

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important: If Iham 27 any injury or other tr

Physician /Medical

Examiner

25. Was case referred to medical examiner? 1 Yes 2 No

> 1 Natural 5 Pending Investigation 2 Accident 3 ☐ Suicide 4 Homicide

6 Could not be determined

28a. Dete of Injury (Month, Day Year)

32. Registrar's Signature

1 ☐ Yes 2 ☐ No 28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled.

(Check only one)

31. Date filed (Month, Day, Year)

DEC 1

29a. Certifier

29c. License number

29d. Date signed (Month, Day, Year)

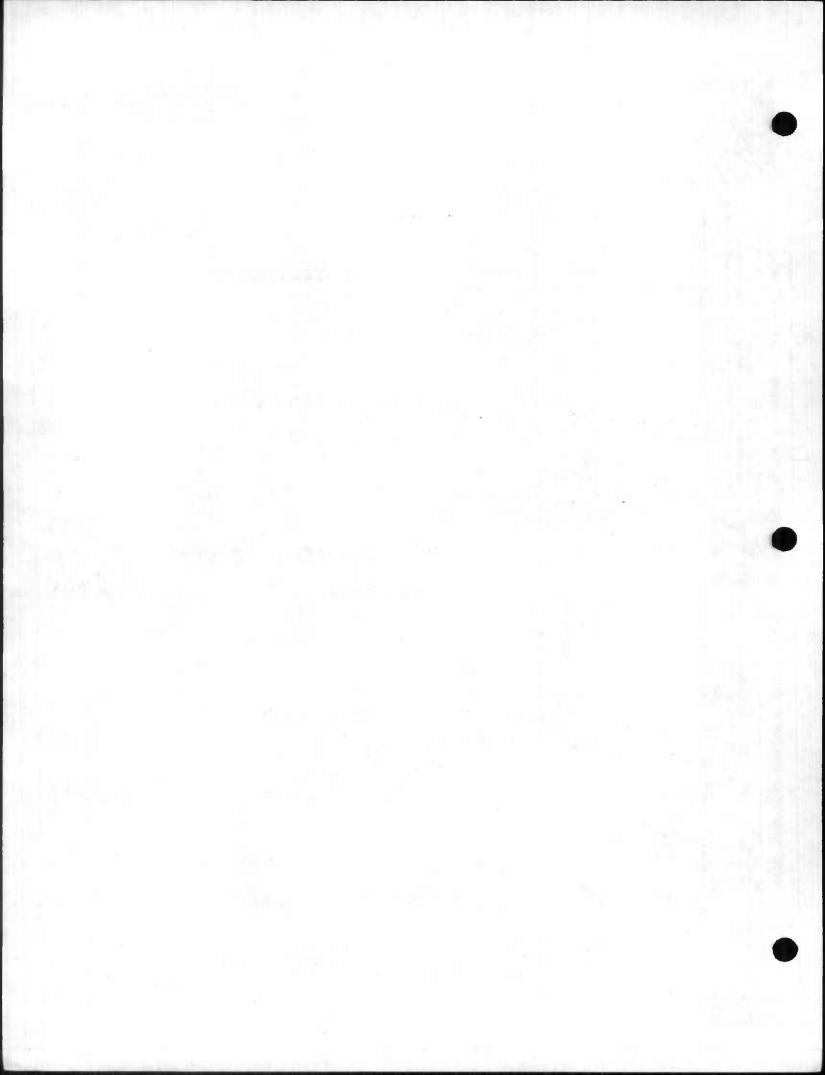
30. Name and address of person who completed cau cause of death (Item 23a) (Type, Print)

al giemp C8370W4

State Registrar

completely

within 2 ş



Please Type or Print in Black Indelibie ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #10G PER F.H. G779 1-27 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month **Physician** Helmut Hermann Wilhelm Brinkmann Dramber 13 /Medical 4e Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Feb. 21, 1926 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XX M 2□ F Months Days 236 72 0491 73 Germany Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. fnside City Limits 28a-f ahow WV Morgan Berkeley Springs 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò U.S.A. CANADA Route 7, Box 13737 25411 Нета 23а 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marifel Stefus Permit. Pages 1 and 2 should be filed within 72 hours after coopertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural". when any injury or other traumatic averages. Bleck, White, etc. 1 Never Married 2 Merried 1 ☐ Yes XX No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Engineer Mining 17. Father's Neme (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Heinrich Brinkmann Minna Ohm 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 7, Box 13737, Berkeley Springs, WV 25411

20b. Place of Disposition (Name of cometery, cremetory or other place)

Dete 20c. Localion - City or Town, State Sara W. Brinkmann 20e. Method of Disposition 1 ☐ Burial 2 🕅 Kremetion 3 ☐ Removel from Stete Dec.17, 1999 Hagerstown, MD 4 □ Donetion 5 □ Other (Specify) Hagerstown Crematory 21. Signature of Funeral Service Licensee 22. Neme and Address of Fecility Helsley-Johnson Funeral Home, Inc. M00522 306 Union St., Berkeley Springs, WV 25411 23a. Part1. Boter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** a. MYO CARDIAL INFARCTION

Due to (or as e consequence of):

Due to (or as e consequence of):

Due to (or as e consequence of): Immediete Cause (Final diseese or condition resulting in deeth) /Medical Examiner Physician/Medical Examine CORANARY ARTORY WILLKARE physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last PBRTON SION Division of Vital Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☐ Onknown by Completed 24b. Were autopsy findings 24a. Wes an autopsy performed? available prior to completion of cause of death? 2□ No 1 □ Yes 2 □ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) axaminer? 1 Nos 2 No Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred edical Certification: 5 Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of fnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. 29a. Certifier within 24 hours To the Fune completely fi (Check only one) To the 29c. License number

D40622 29d. Date signed (Month, Day, Year) 29b. Signefure end title of certifier DECEMBER 13, 1999. MAD

Registrar

State

31. Dete filed (Month, Day, Year)

DEC 1 5 1999

Brinkmann, Helmud

32. Registrer's Signeture

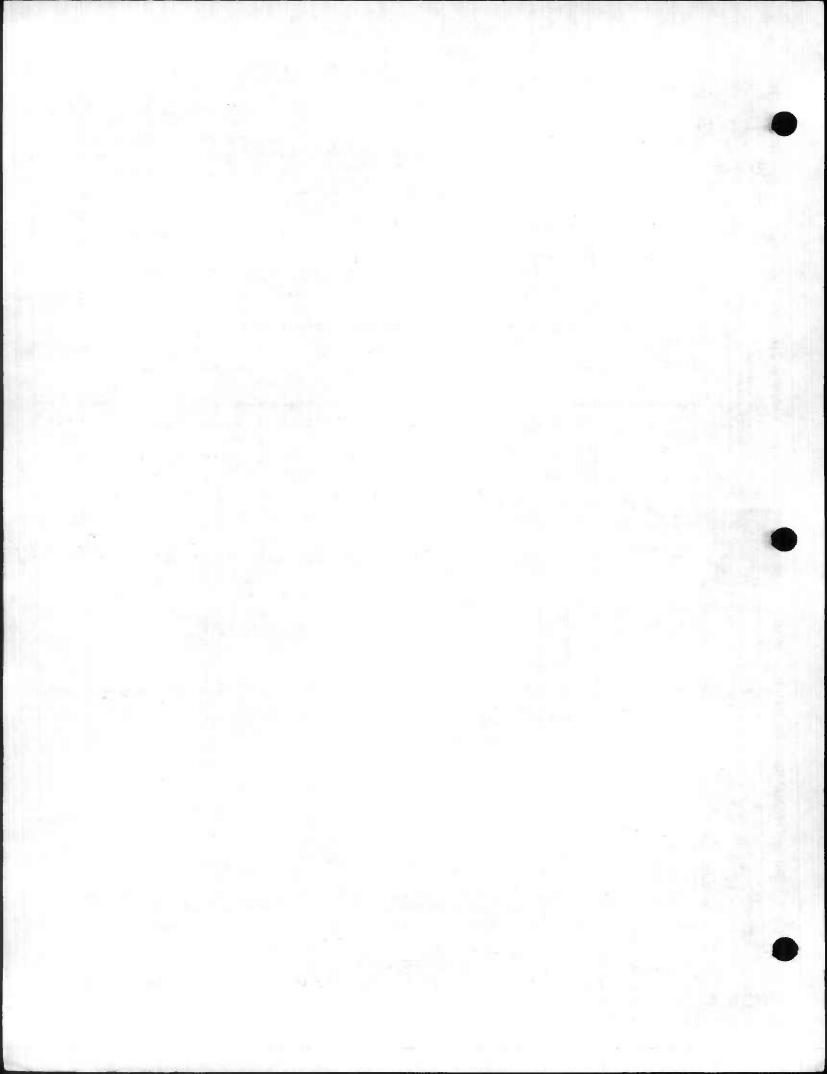
Teneva

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

EXNEST UET CANIN MD, 19236 MGROWN VION DRIVE, ARBEXSTON MD21442

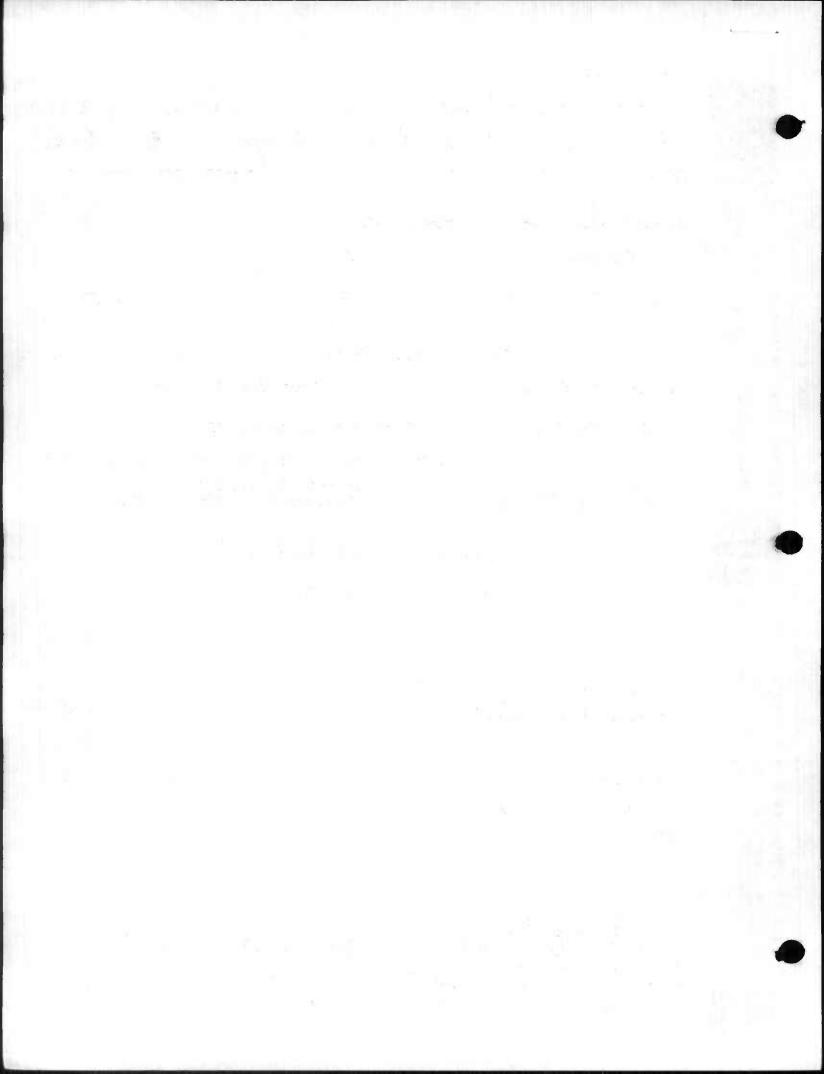
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Į.	Physici /Medic		Dora Mae BONEBRA	KE						Decembe		99	7:55 pm	,
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	Funeral Director		5. Social Security Number 6. 214-09-4126 Usual Residence of Decedent	Sex 7. Age	85	Yrs.	Months Day		Min.	8. Date of Birth (Month, Day, Sept. 3	Year) 0,1914	Coun	lace (Stete or Foreign stry) yland	
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Balt	permit. Pages Department of Important: If I any Injury or otics.		21. Signeture of Funerel Service Lic	ensee	ξ.		Name end Add			MINNICE ., Hager				
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Division	of or Attand efter death Director: /	Certification:	3 Suicide 6 Could not determine		ry - At home, for C. (Specify)	erm, stre	et, fectory, offic	8		28f. Location (Sti City or Town		er or Aura	al Route Number,	
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			30. Name and address of person wh	o completed cause of de	ath (Item 23a)	(Type, F	Print)	277/1	1-11	D La	es o Her	un	ms sill	1
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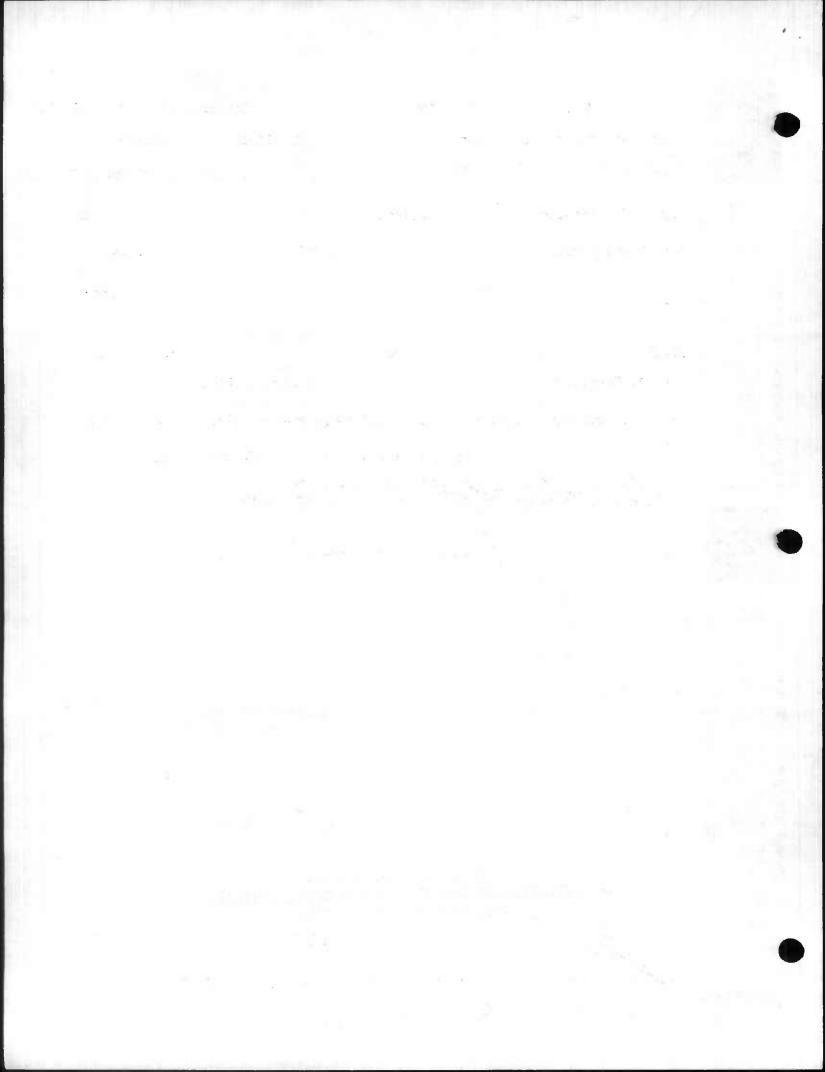
State of Maryland / Department of Health and Mental Hygiene 99 1, 1599

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State of Maryland / Department of Health and Mental Hygiene q q

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3	Examir	er	4e. Fecility Neme (If not institution, give street and number)	4	b. City, Town, or L					
			Alice Byrd Tawes Nursing Home 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If	Under 1 Year	Crisfi	T-		erset		
ė	Funeral Director			onths Deys	Hours Min.	8. Date of Birt (Month, Day December	12, 189	9. Birthple Count Nor	ece (State try) th Ca	or Foreign
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	h with tha	Funeral Director	10e. Street end Number 315 W. Main Street	Of. Zip Code	.817		10g. Citizen of V	Whet Count	try?	
020	permit. Pagas 1 and 2 should be filled within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises must be notified at once.	by	1 Never Married 2 Married 1 □ Yes 2 No	Decedent of Hes, specify Cube	ispenic Origin? (Sp en, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Blace Specify	e - America ck, White, e	etc.	
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Maryland	ould be f Mental It arked of atic eve	Be	John A. Bradshaw		Evelyn			Θ)		
2	should nd Mer marke imatic	2	19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing A	ddress (Street	and Number or Rui			State Zin	Code)	
	ond 2 states and 2 states are trau				er Road -			218	_	
re,	is 1 and 2 if Haalth Itam 27 other tr		20a. Method of Disposition 20b. Place of Disposition	on (Name of		Dete	20c. Location -			_
m	Pagas nant of I ant: if Its ary or o		1 Burial 2 □ Cremation 3 □ Removel from State 4 □ Donation 5 □ Other (Specify)			2/16/99	Crisfie	eld, 1	MD	
Baltimore,	permit. Departm Importa any inju			w. Mai sfield,		17				
,	Physician /Medical Examiner	- G	23e. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart feiture. List only one ceuse on each line. Immediate Ceuse (Finel disease or condition resulting in death) Due to (or es e consequent	mix					Approxime Intervel Be Onset end	etween
Box 68760,	death certificata be executed e attanding physician end ed for usa as the burial-transit	an/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last b. Due to (or es e consequence cause. Enter Underlying Ceuse (Disease or Injury that initiated events are underlying consequence cause.) Due to (or es e consequence cause) consequence cause consequence cause consequence cause c							
	deat deat ed fo	sici	Part II. Other significent conditions contributing to death but not resulting in the under	dying cause giv	en in Pert I.	23b. Did t	obacco usa cor	ntributa to	the cause	of death?
s, P.O.	requiras that tha death cert een signed by the attandin hould be dateched for usa	by Physician/N			_	10	Yes 2□ No	3 Prob	ably 4	Unknown
Records,	2 S S	Completed t				24e. Wes perlo	an eutopsy rmed?	ave	re eutopsy ileble prior npletion of leeth?	rto
	Tha ate t	Co				101	es 2 No	10	Yes 2	□ No
Vita	certificate rector, pag	Be	25. Wes case referred to medical exeminer?	l Out	26. Place of Deel	h (Check only o	ne)			
ō	Phys this al di	2		3 DOA Oth	4 LIF Nursing Ho		lence 6 Oth)	
Division	After funa	cation	1 DMeturel 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident Investigation	28c. Injun Work	y et k? Yes 2 □ No	28d. Describe r	low injury occurr	90		
	2 2 2 2	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office		28f. Location (S City or Tow	Street and Numb m, State)	er or Aural	Route Nu	m <i>ber</i> ,
	To the Hospital or Attend within 24 hours efter deatl To the Funeral Director: complately filled in by tha	edical	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, death occurrence on the best of exeminetion end/or investigation and manner stated.	curred et the tin igetion, in my o	ne, dete end plece, pinion, death occur	end due to the ored et the time,	ceuse(s) end me date end plece, d	nner as ste and due lo	eted. the cause	(s)
	Withir To th comp	M	29b. Signeture end title of seasons	29c. License	e number		29d. Date signed	d (Month, L	Day, Year)	
				D 00	47637		Dec. 15	5, 199	99	
			30 Name and of person who completed cause of death (Item 23e) (Type, Print Torcon). The control of person who completed cause of death (Item 23e) (Type, Print Torcon).		dasi-sa	MD 014	017			
	Sta	0	Joseph Inzerillo, M.D 320 W. Main 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture	St Cr	isrield,	MD 218	21 /			
	Registr		DFC 1 7 1999 Beneva G	1						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month CARRIE ELEANOR CRONISE December 21 - 99 1535 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1□ M 2⊠ F 88 214-09-3019 DEC. 23, 1910 MARYLAND Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MARYLAND WASHINGTON HAGERSTOWN 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 76 DEVONSHIRE ROAD 21740 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Nidowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 ASSEMBLER AIRCRAFT MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CLAYTON E. SMITH FANNIE E. SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print)

328 S. Mont Villa Ave., Hagerstown, MD 21740

Date

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

21713

12/24/99 BOONSBORO, MARYLAND

7606 Old National Pike

Boonsboro, Maryland

Pages 1 and 2 should be filed within 72 ho nant of Health and Mental Hygiena. ant: If Itam 27 is marked other than "natur ury or other traumatic avent, the Hedical. Baltimore, Maryland Department of Important: If any Injury or Dates.

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23s or 28s-f show

Director

Funeral

p

Completed

8

KATHLEEN KEGARISE/FRIEND

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

29b. Signature and title of certifier

ar 31. Date filed (Menth, Day, Year) DEC 2 3 1999

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

P. Steven Danfelt Jr.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Malik

20a. Method of Disposition

the Maryland

illed within 72 hours after death with

21215-0020

Physician /Medical Examiner

physician the burial

for use I

After this

death.

6

after death

within 24 hours a To the Funeral D

funaral

Box 68760,

P.O.

Vital Records,

Immediate Cause (Final disease or condition resulting in death) anduac Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last oronary Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Be Completed è Heart Failure 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

MD

32. Registrar's Signature

elt, TR

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BOONSBORO CEMETERY

22. Name and Address of Facility

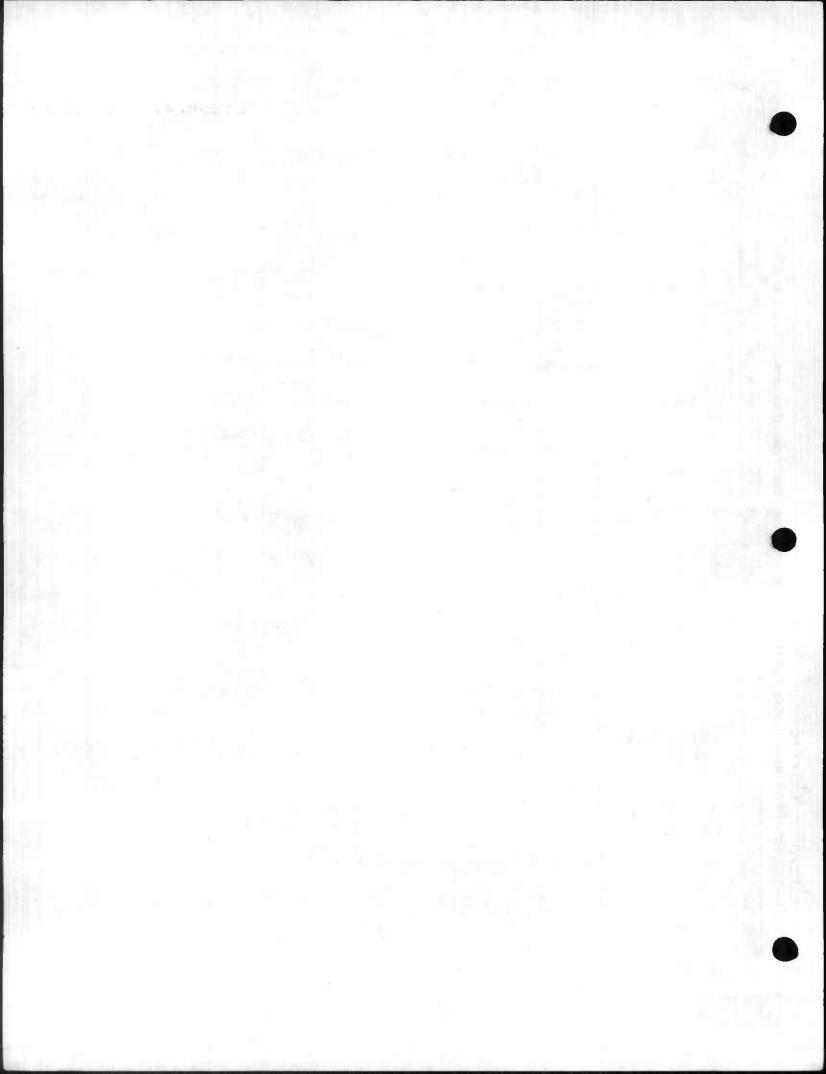
Bast Funeral Home

State Registrar

20311

29c. License number

044996



State of Maryland / Department of Health and Mental Hygiene 41541 Certificate of Death

Physician
/Medical
Examiner

Baltimore, Maryland 21215-0020

Phys /Me Exa

To the Hospital or Attending Physician: The lew requires that the death certificate be assect within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

CLINGAN, Mildred Mae

in	MILD			INGAN					Month DECEMBE	Day	Year 999	8:30 PM
al er	4a Facility Name (I	not institution, giv	e street and number	or)				4b. City, Town, or		4c. County		
	RAVENWO	OD LUTHE	RAN VILLA	GE				HAGERST	OWN	WAS	HING'	ron
	5. Social Security N 218-30-	9252	Sex 7.4	Age (In yrs. 80	last birthde Yrs.	Month	der 1 Year hs Days	If Under 24 Hrs Hours Min.		Year) 23,191	9. Birthp Coun 8 M	lace (State or Foreign stry) aryland
	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or	Location					1	Od. Inside City Limits
	Maryland	Washi	ngton	-	lagei	sto	νn					1 Yes 2 No
1	10e. Street and Nur						Zip Code		10	Og. Citizen of W	hat Coun	itry?
	1183 L	uther D	rive				217	40	11.	U.S.	Α.	
		ed 2 Married	12. Was Deceder Armed Force 1 Yes 2 I	a?	,S. 1			tispanic Origin? (S an, Mexican, Puerl Specify:	specify Yes or No- to Rican, etc.)	Black	- Americ , White, Whi	
	3 D Widowed	4 Divorced	Year or Date:	s:								
	(Spec	15. Decedent's En ify only highest gra	ducation ade completed)		16a. De	cedent's U	work done	eation during most of world)	rking	16b. Kind of Bu	siness/Inc	dustry
	Elamentary/Seco	ndary (0-12)	College (1-4c	r 5+)			Cler			Departm	ent	Store
	17. Father's Name	First, Middle, Last)					18. Mother's Nar	me (First, Middle, A			
I	Edga			Jones				Marv	Fliza	beth	La	nders
1	19a. Informant's Na			01103		ailing Addr	ess (Street		ural Routa Number			
I	Harold	Jones	- Brothe	er	972	7 Sha	rpsbu	rg Pike.	Hagersto	own. Md.	. 217	740
	20a. Method of Disp				Place of Dis	sposition (1		20c. Location - (
		☐ Cremation 3 ☐ 5 ☐ Other (Specil	Removal from Sta	le e					_23_99	Hanoret	OWD	Maryland
	21. Signature of Fu	neral Service Licer	nseg, /		30 110	22. Name	and Addre	ss of Facility				Har yrand
	P	hooly	Brady	-					Funeral			04740
+	23a. Part 1. Enter fl	ne disease, or com	plications that caus	ed the deat	h. Do not	enter the n	OST F	INTIETAM ng, such as cerdia	Street, F	lagersto st,	own,	Md. 21740 Approximate
	ahock, or hea	t failure. List only	one cause on each	fine.							i	Interval Between Onset and Death
	Immediate Cause (Pro	um						1	3-4 wms
	disease or condition resulting in death)	n	a		or as a con		oD:			_	- 1	2
I				200 10 (0	, uo u oon	ooquo.noo .	01,1				i	
	Sequentially list confirmers, leading to Imcausa. Enter Under Causa (Disease or that initiated events	nditions, mediate rlying	b	Due to (o	or as a con	sequence	of):					
cial vinedical	Cause (Disease or that initiated events rasulting in death) i	injury .ast	c	Due to (o	r aa a cons	sequence o	of):					1 1 1
		-	d								-	
	Part II. Other signif	cent conditions o	ontribution to death	but not res	ulting in th	a undarhin	na causa ai	ren in Part I	23h Did to	bacco use con	tribute to	the cause of death
		arkino			My	perei	wing.		The state of the s			bably 4@Unknow
in and in a									24a. Was a perform		8V 00	ere autopsy findings allable prior to mpletion of ceuse death?
									1 🗆 Ye	s 219No	10	Yes 2□ No
	25. Was casa rater	ed to medical						26. Place of De	ath (Check only on	θ)		
	1 Yes 2	No	Hospital: 1 Inpa	itient 2	ER/Outpa	tient 3	DOA OH	ner: 4 Nursing I	Home 5 Reside	nce 8 DOthe	er (Specif	y)
	27. Mannar of Deall 1 Natural 2 Accident	5 Pending investigation	n	njury Day Year)	28b. Time Injur		28c. fnju Wo 1	y at rk? Yes 2 ☐ No	28d. Describe ho	w injury occum	ed	
	3 ☐ Suicide 4 ☐ Homicide	6 Could not b datarmined	28a. Place of	Injury - At ho etc. <i>(Specif</i>	ome, farm,	street, fac	tory, office		28f. Location (St City or Town	reet and Numbon, State)	er or Run	al Route Number,
100	29a. Certifier (Check only one)		ysician: To the besininer: On the basis and manner	of axamina								
	29b. Signature and	title of certifier					29c. Licens	se number	2	9d. Date signed	(Month,	Day, Year)
		~	anstro				D18	019		DEC 2	-0,(999

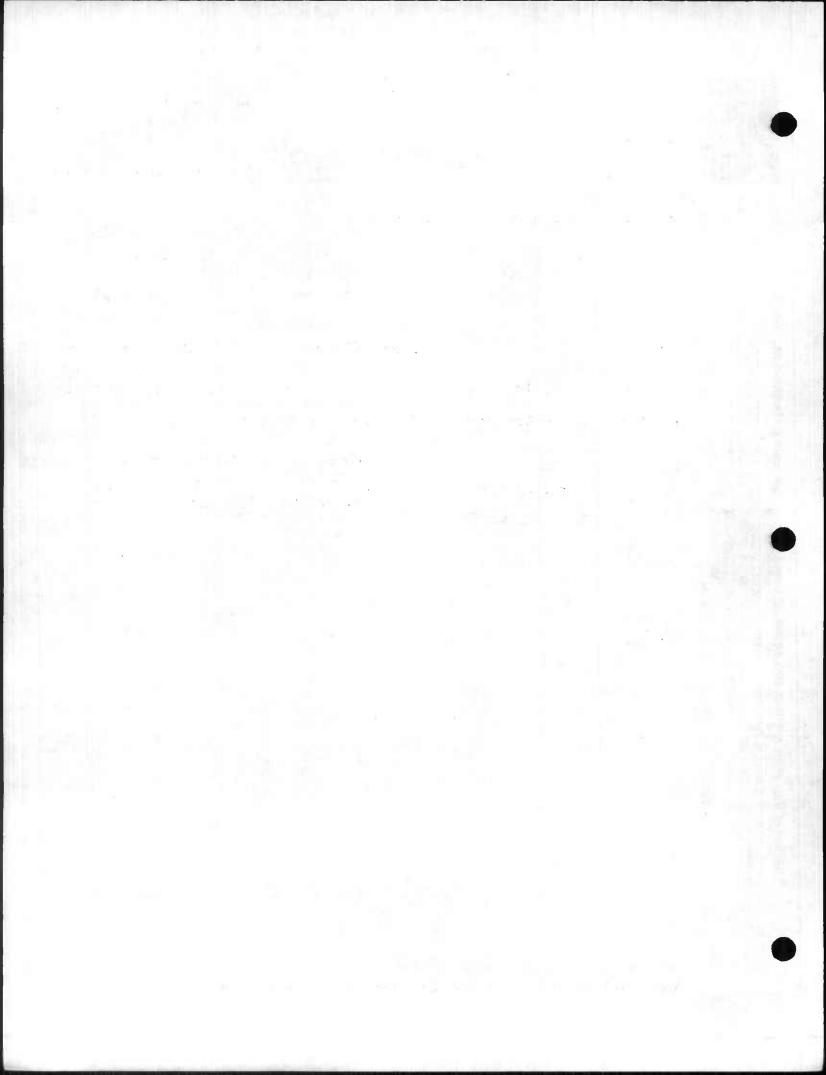
State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

334 Mill S4. 32. Registrar's Signature

PASONT DATTA M.D

31. Date filed (Month, Day, Year)
DEC 2 1



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Day **Physician** Lillian Theresa Christy December 17, 1999 tion of Death 4c. County of Deat 752 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington Washington County Hospital Hagerstown Months Days Hours Min. Ap/1911 Pay, Year 936 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplaca (State or Foraign **Funeral** Wisconsin 1 M 2 TXF 398-32-8205 63 Yrs. Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or items 23s or 28s-f shorts Medical Examiner must be notified at 1 ☐ Yes 2X No Funeral Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 21740 U.S.A. 13822 Northcrest Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status filed within 72 hours after 1 Yes 2 Tho
If Yes, Give X
Year or Dates: 1 ☐ Never Married 2 ☑ Married 1□ Yes 2ENo white 21215-0020 Specify: Specify Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within : Department of Health and Mental Hyglens. Important: if item 27 is marked other than "n eny injury or other traumatic event, this Med DRES. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Philis Alexander Winski Koceja 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13822 Northcrest Rd. Hagerstown, MD 21740 Carl L. Christy spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata XI Burial 2 ☐ Cremation 3 ☐ Removat from State 12-22-99 Hagerstown, MD Rest Haven Cemetery 4 ☐ Donation /5 ☐ Other (Specify) 21. Signature of Fund al Service Licensée 22. Nama and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 21742 Enter the diameter, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, , or heart failure. List only one cappy on such line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Ten hejunt Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Box 68760. Physician/Medical that initiated events resulting in death) Last for use P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? page 2 should be detached Yea 2 No 3 Probably 4 Unknown Division of Vital Records. Be Completed by 24b. Were autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performed? certificate has 1 Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Inpatient 2ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and stip of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

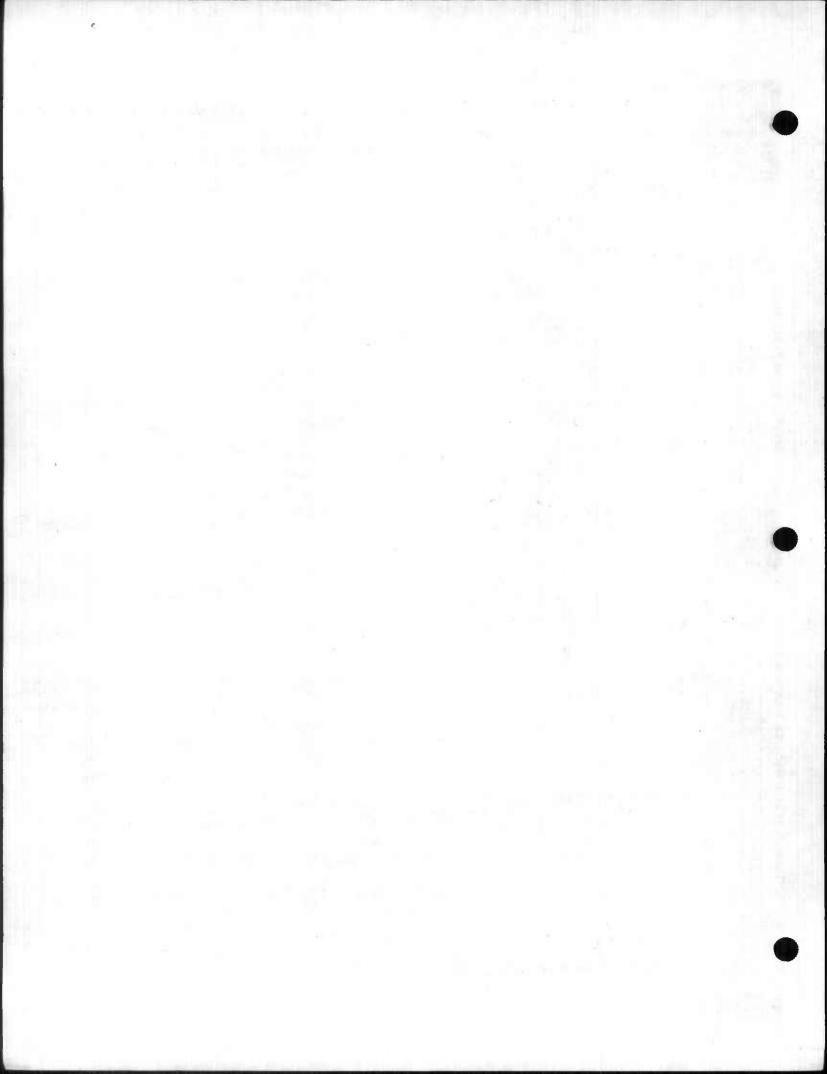
Registrar DHMH 16 Rev 6/95

State

31. Date filed (Month, Day, Year)

32 Registrar's Signature

LST. HAGERSTOWN MI)



State Registrar 31. Date filed (Month, Day, Year)

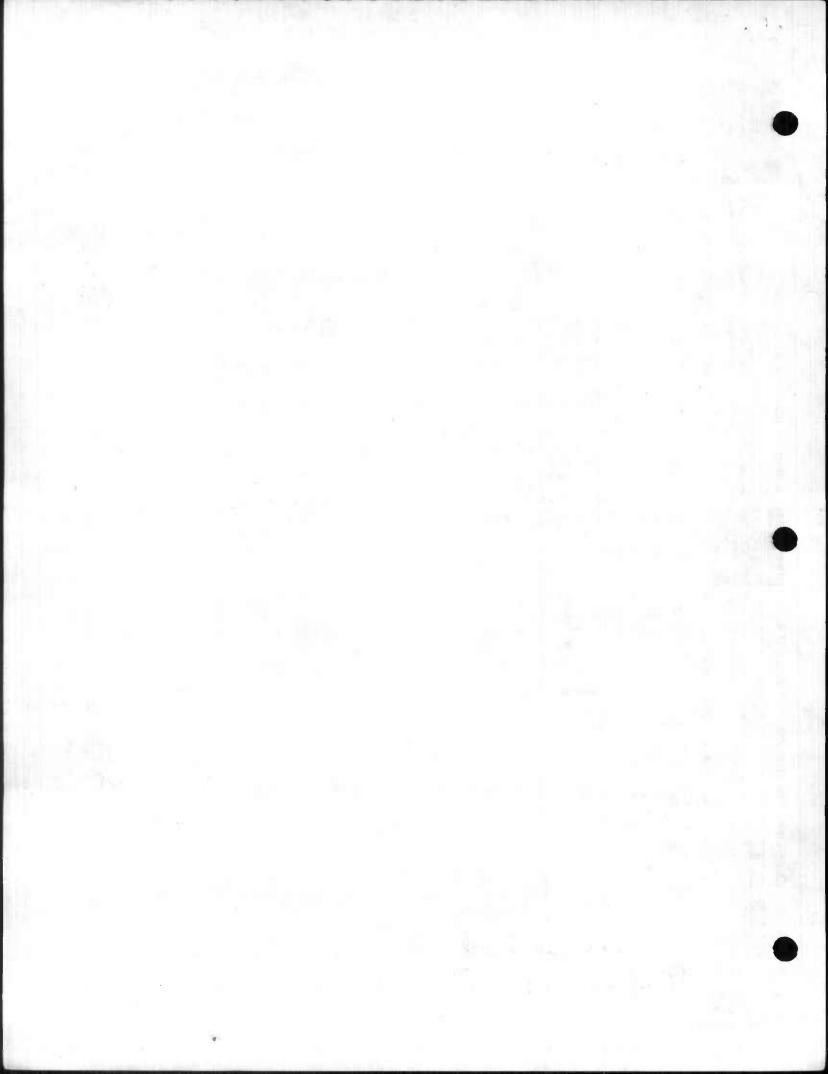
DHMH 16 Rev 6/95

111 Penn Street, Baltimore, Maryland 21201

is of person who completed cause of death (ttem 23a) (Type, Print)

32. Registrar's Signatura

Dener



Jushua, Kichard

Box 68760,	
, P.O.	
Records	
of Vital	
Division (
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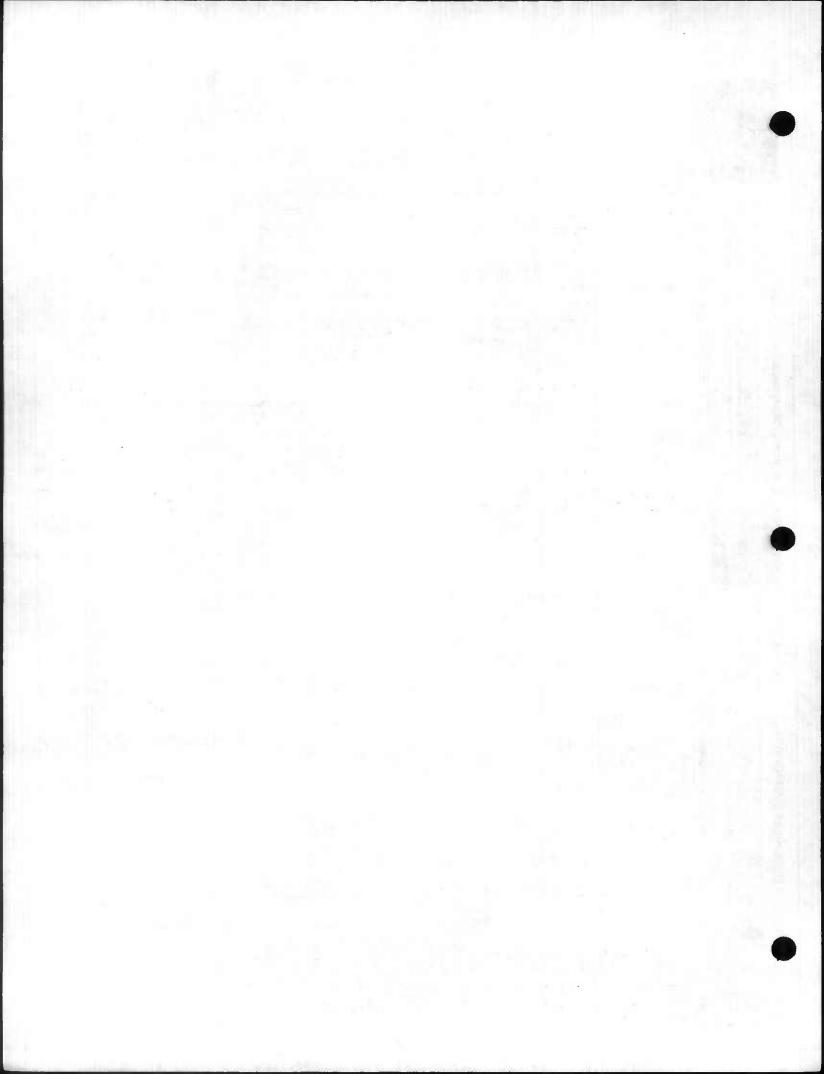
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Richard Leon Cushwa Dec 1999 1600 /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death Examiner Washington County Hospital Hagerstown, Washington Months Deys Hours Min. A Month Pay 4 earl 911 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ★M 2 F 88 214-01-8992 Yrs. Director MD Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits MD Washington Maugansville Mary 2 □ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13715 Village Mill Drive 21767 U.S.A. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2/23/No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried Specify: White Baltimore, Maryland 21215-0020 1□Yes 2\No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) wood mfg. College (1-4or 5+) Cabinet Maker 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 Richard Eugene Cushwa Julia Seibert 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) If it Heelth a William 14335 Spickler Rd. Clear Spring, MD 21722 Cushwa 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Steta 20e. Method of Disposition Date 1 Suriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Department of Important: If any Injury or ance. St. Paul Cemetery Dec. 13, 1999 Clear Spring, MD of Funeral Service Liceris 22. Neme end Address of Fecility Donald Edwin Thompson Funeral Home, Inc 23a Paul 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. MD 21722 Approximate and ck, or hear feilure. List only one ceuse on each line. Interval Between Onset and Deeth **Physician** /Medical Immediete Cause (Final Examiner Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last and Due to (or es a consequence of) attending physician the Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown Urosepsis Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? To the Hospital or Attending Physicians, within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 DNO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 1 Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) end manner as stated. 29e. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end-manner steted. 29b. Signature and title of certifie 29d. Dete signed (Month, Day, Year) 30. Neme and address of person who templeted cause of death (Item 23a) (Type, Print) Hagerstown MD 21142 Charles C. Spencer 11110 Medical Comput Rd

State Registrar

DHMH 16 Rev 6/95

32. Registrer's Signeture



Please Type or Print in Black Indeiible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Dala of Death DECEMBEE N 1999 Physician 10 15A 4NNE Eleanor CRONIN /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fallston If Under 24 Hrs. Hours | Min. Fallston General Hospital Harford If Under 1 Yaar 8. Dala of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 25 F 76 Director 144-12-9400 Dec. 8, 1923 New Jersey Usual Rasidence of Decedant the Maryland 10a. Slata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 601 Winslow Dr. 21015 238 USA deeth Funeral 14. Race - American Indian, 12. Was Decedenl Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status Black, Whita, atc. should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yas 212 No If Yes, Giva 1 ☐ Nevar Merriad 2X Married 21215-0020 1 Yas 2 No Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) 12 Manager Insurance Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Surnama) Pages 1 end 2 should be nent of Health and Mental Edward Franklin Weddle Elizabeth Winifred Farrell 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Department of Health in Important: If frem 27 is any injury or other tra Walter J. Cronin - Husband 601 Winslow Dr., Bel Air, Maryland 21015 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Cramation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Gertrudes Cemetery 12-20-99 Colonia, New Jersey 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility McComas Funeral Home, P.A. 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediala Causa (Final Ventricular Fibrillation One minute disaasa or condition rasulting in death) Examiner Dua to (or as a consequance of): Examiner Cardiomyopathu 104ears physician and the burial-transit be executed Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting In death) Last coronary artery disease 15 years Box 68760. Physician/Medicai Dua to (or as a consequence of) 50 950 P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown ģ Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en autopsy parformed? 2 ZNO 1 Yas 25 No Division of Vital or Attanding Physician: 25. Was case rafarred to medical examinar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) 1 Yas 2 No Hospital: Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dala of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28b. Tima of 28d. Dascribe how injury occurred Natural 5 Pending 1 ☐ Yas 2 ☐ No 24 hours after death. Funeral Director: A € Accident investigation 6 Could not be datermined 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicida 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 175 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end mannar as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one)

Hospital

Ann

State

Registrar

31. Data filed (Month, Day, Year)

michael M. Diossner, M.D.

29b. Signatura and titla of certifian

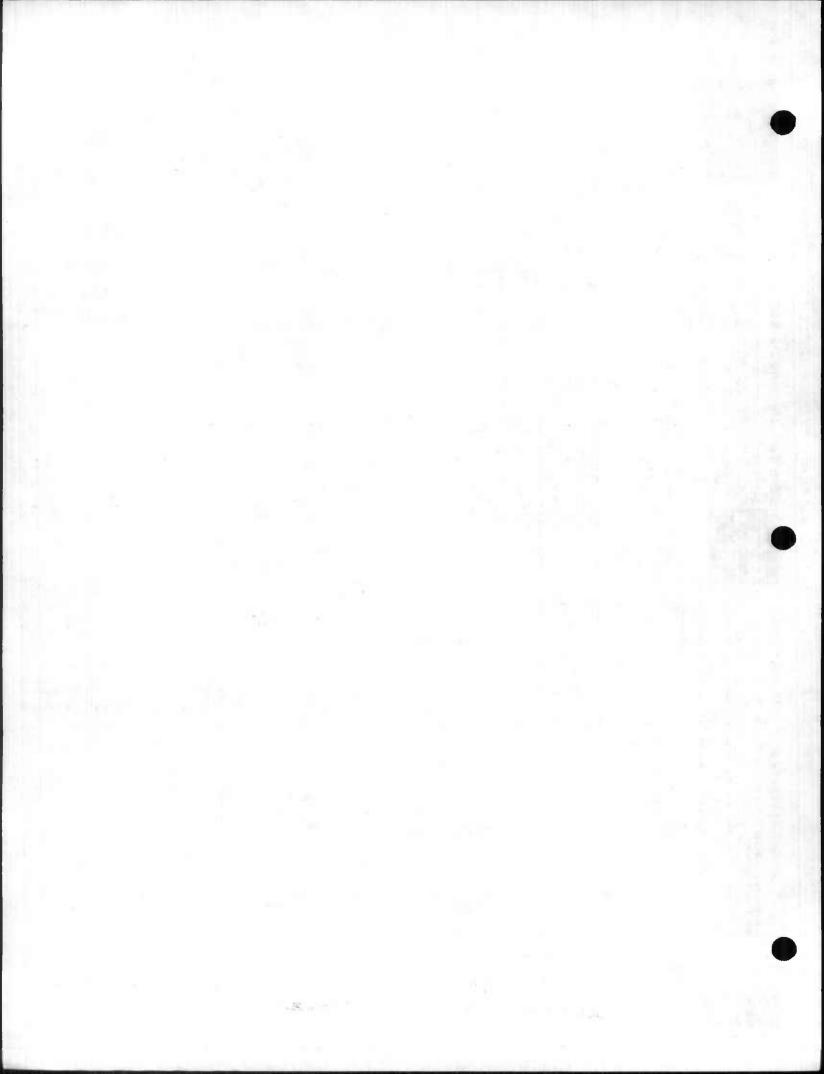
D32288 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Dala signed (Month, Day, Year)

December 16, 1999

Michael N. Drossner, MD, 104 Pruntree Road, Suite 110, Bel Air, Maryland 21015 32. Registrati's Signature DEC 16 1999

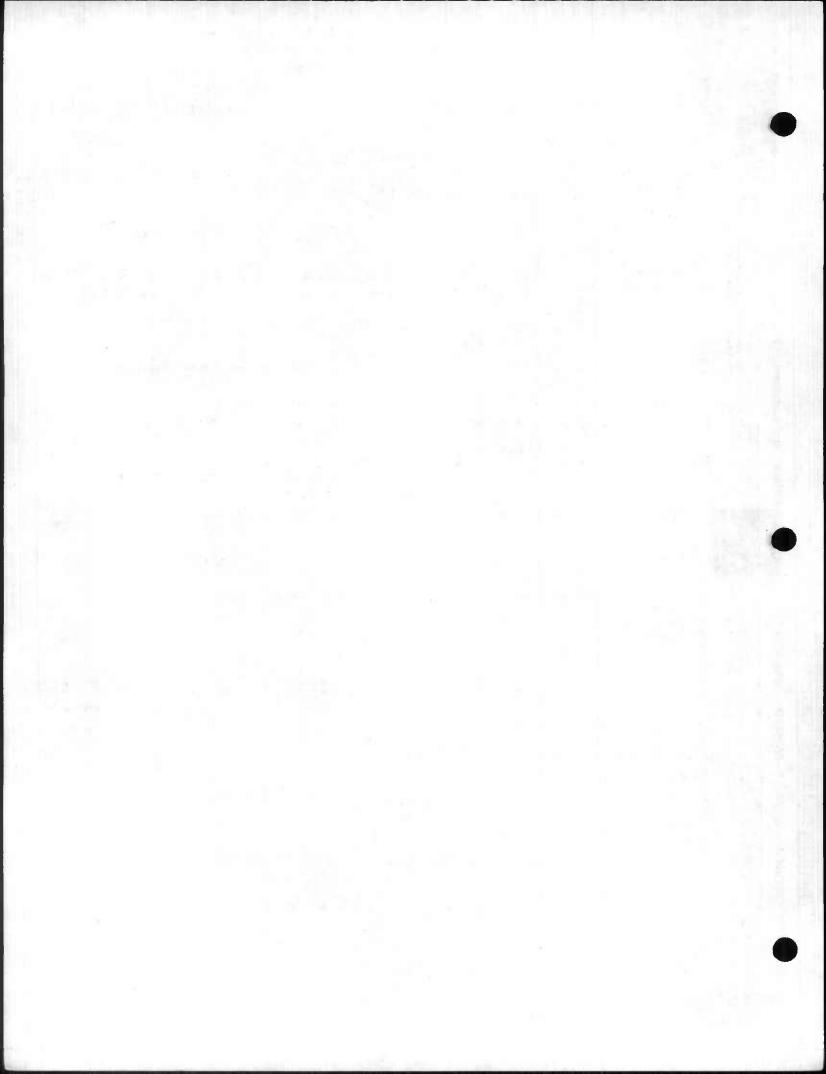


Funeral Director 28a-f b Nems 23s 'natural', or Hygiena. and Mental Hygi Health

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Violet Delsie DELAUDER Drember /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 5. Sociel Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1□ M 2⊠ F 214-09-4253 Feb. 23, 1917 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠ Yes 2□ No Maryland Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 542 Chestnut Street 21740 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dales: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Meritel Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: white Specify: by 3 □ Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) seamstress clothing mfg. 8 0 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maideo Surneme) Be Pages 1 and 2 should be Mabel Butts Louis Hasenbuhler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type Print) Important: If Item 27 any Injury or other tr David E. Delauder - husband 542 Chestnut St., Hagerstown, Md. 21740 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Slate 8 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 12-24-99 Hagerstown, Maryland 21. Signeture of Funeral Service Licensee 22, Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final diseese or conditi-resulting in death) ear Examine Examiner heres physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca ot): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca ot): Part tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 →No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case reterred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 □ ER/Outpatient 3 □ DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? 1 Natural 5 Pending 1 Yes 2 No death. investigetion 2 Accident aftar death Director: 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide 24 hours a edical 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stetylidi To the To To the F 29b. Signature and title of certified 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 and 11111 31. Date tiled (Month, Dey, Year) 32. Reģistrar's Signature State 1999 DEC 23 Registrar

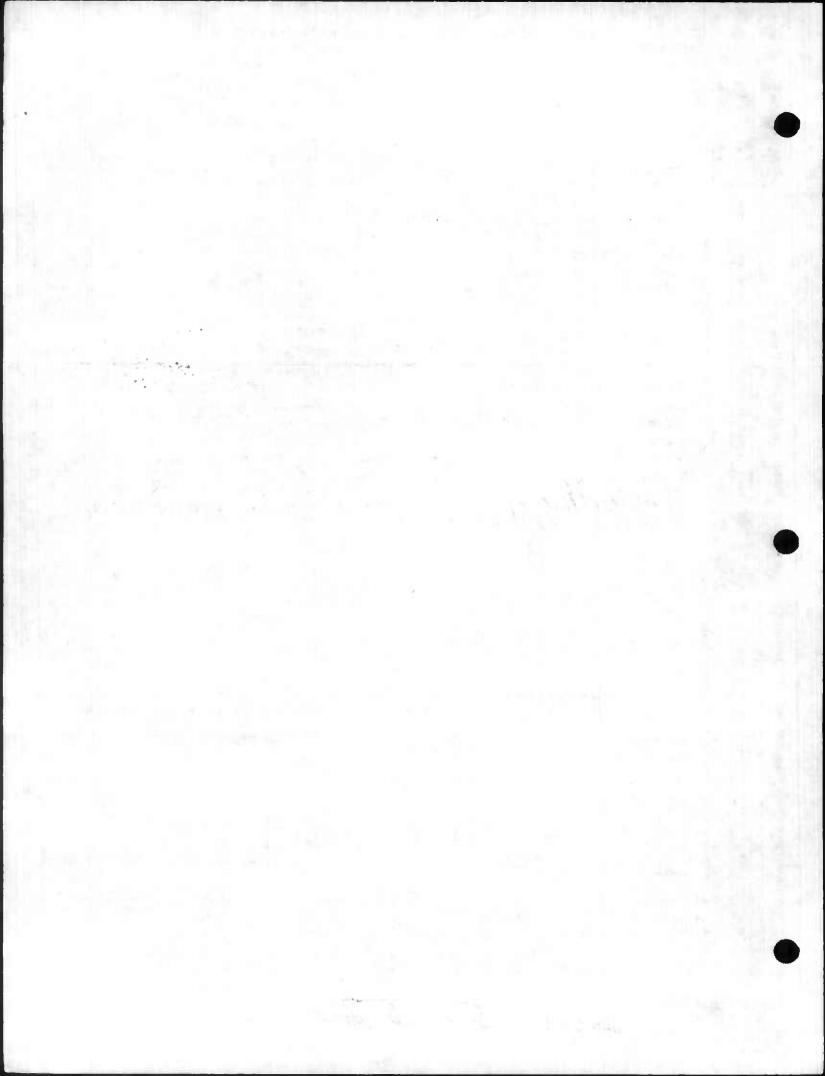
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Elaudes, Violet Delsie



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	На	rford Me	morial H	ospita				Grace		rford	
al or	5. Social Security Number 218-86-0328	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs		Months Dey		Min.	B. Dete of Birth (Month, Dey, Oct. 16	Year) , 1976	9. Birthplece Country) Marylai	(State or Foreign
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To Be	17. Fether's Neme (First, Middle, George Edward		III			Ann	Mana	kee Lan	mbdin		
	19e. informent's Name/Reletions George E. Drun		'Father		ng Address (Street)						e)
	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion	3 □Removal fro		Plece of Dispo cemetery, cre	osition (Neme of metory or other p	plece)		Dete	20c. Location -	City or Town, S	State
	4 Donetion 5 Other (S		Hi		Service			31/99	Towson	, MD	
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Examiner	C)*	b			D.						
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2 Date of Death 3 Time of Death **Physician** 6:30 AM December 18, 1999 CHARLOTTE IRENE DAVIS /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 09/10/1908 Birthpiace (State or Foreign Country)
 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 25 F Yrs. 219-36-3842 Director Usual Residence of Decedent 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show 1 Yes 2 □ No Director MARYLAND WASHINGTON SHARPSBURG 10g. Citizen of What Country? 10e Street and Number 10f. Zio Code ŏ permit. Peges 1 and 2 should be filled within 72 hours affar death w Department of Health and Mentel Hygiene. Important: If Nem 27 is marked other than "natural, or Itema 23a any Injury or other traumatic event, tra Manne 201 WEST MAIN STREET 21782 U.S.A. Funeral 12. Waa Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Datas: 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yaa or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE 2 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOL TEACHER YEARS STATE GOVERNMENT 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middla, Maiden Sumame) Be JOHN WALTER ROULETTE MYRTA I. SNAVELY 19a, Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) SANDRA S. GUESSFORD/DAUGHTER P.O. BOX 395, SHARPSBURG, MARYLAND 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata TD Burial 2 Cramation 3 Removal from Stata
4 Donation 5 Othar (Specify) MOUNTAIN VIEW CEMETERY 12/21/99 SHARPSBURG, MARYLAND 21. Signatura of Funaral Service License 87.OA 22. Nama and Addrass of Facility 7606 OLD NATIONAL PIKE BOONSBORO, MARYLAND 21713 STEVEN DANFELT, JR. BAST FUNERAL HOME 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** Immediata Causa (Final disaasa or condition resulting in death) Acule Renal Facture /Medical Examiner Examiner certificate be executed Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disease or Injury that initiated events rasulting In death) Last by chatch

Oue to (or as a consequence of): Box 68760 Physician/Medical obstruction P.O. 1 Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, p 24b. Wara autopsy findings availabla prior to completion of cause of daath? 24a. Was an autopsy Completed 1 ☐ Yas No 1 ☐ Yas 2 ☐ No Hospital or Attending Physician: Be 25. Was casa rafarred to medical 26. Place of Death (Check only ona) axaminar? Hospital: 10 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred After 1 Matural 2 Accident 5 Pending after death. Director: Aft 1 ☐ Yas 2 ☐ No invastigation 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 I Homicida To the Hospital or within 24 hours at To the Funeral D 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. License number December 18, 1999 D44996 30. Nama and address of person who completed causa of death (Item 23a) (Type, Print) 2031/ Cappans Rd -Malike MD La

Registrar **DHMH 16 Rev 6/95**

State

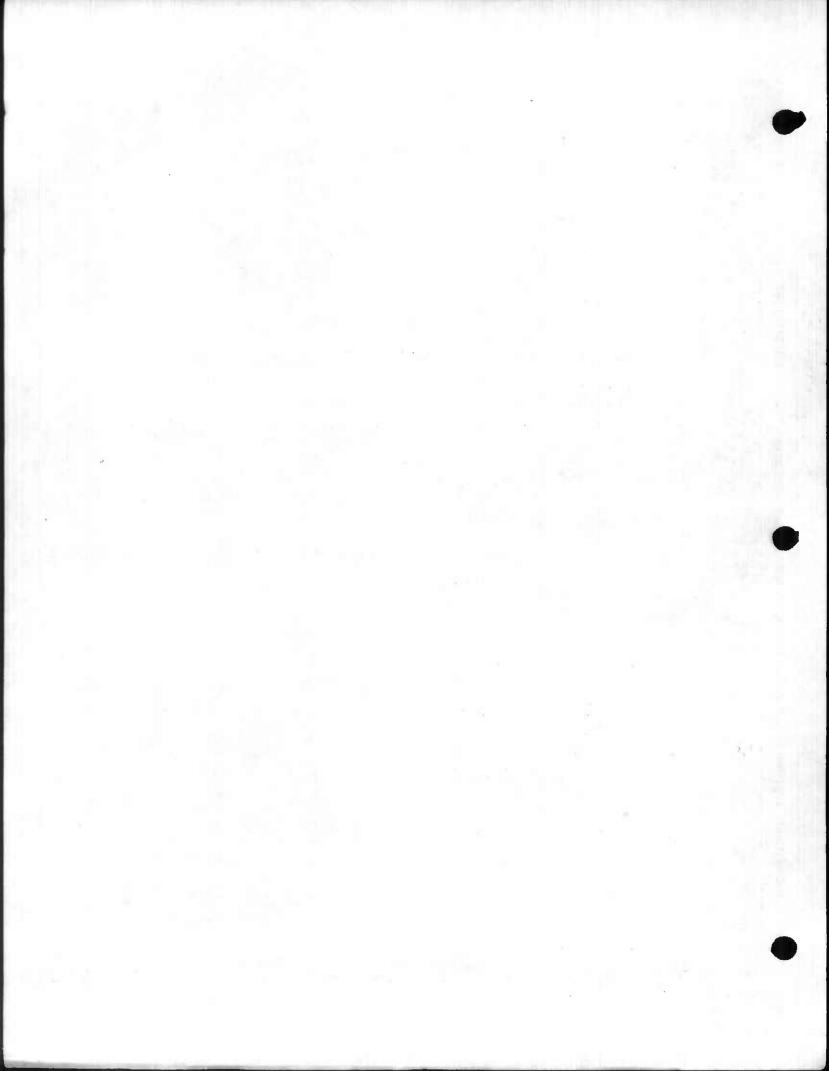
Charlett

2000

Boonstoro, MD 21713

31. Data filed (Month, Day, Year) 1999

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Nama (First Middle Last) 2. Data of Death 3. Time of Death **Physician** Erma Faye DAVIS 18 10:40 a.m. 1999 Dec. /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Williamsport Nursing Home Williamsport Washington 5. Social Security Number If Undar 1 Yaar If Undar 24 Hrs. 9. Birthplaca (Stata or Foreign Country) W. Virginia 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** 1□M 2\ F Yrs. Director 89 218-34-2899 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show 1 ☐ Yas 2 ☑ No Director Maryland Washington Maugansville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours efter death vent of Health and Mental Hygiene.
Int: If from 27 is marked outber than "natural", or items 23, into or other traumatic avent, the Next and Experient many or other traumatic avent, the Next and Experient man. 205 Main Street 21767 12. Was Decedant Evar in U,S Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puerto Rican, atc.) 14. Race - Amaricen Indian, Black, White, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: White Completed by 3 ◯ Widowed 4 □ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondary (0-12) Collega (1-4or 5+) 8 Cashier Grocery Store 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumeme) Be Isaac Brown Ida Cougar 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Dorothy Martin - Daughter 241 Trouble Lane Falling Waters, W. Va. 25419 20b. Place of Disposition (Nema of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Spacify) permit. Page Department of important: If eny injury or once. 12/22/99 Hagerstown, Maryland Rest Haven Cemetery 21. Signature of Funeral Service Licenses 22. Nama and Addrass of Facility Minnich Funeral Home LVestas 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intarval Batween **Physician** /Medical Immediata Cause (Finel cerebrovascular accident disaasa or condition rasulting in daath) Years Examiner Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata ceuse. Entar Undarlying Cause (Disease or Injury that initiated avants rasulting in death) Last Dua to (or as a consequance of): Box 68760, Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown hypertension hypothyroidism, osteoarthritis Division of Vital Records. Be Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? depression 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was cese referred to medicel axaminar? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Certification: To in by the funeral 27. Manner of Daath 28b. Tima of 28d. Dascribe how Injury occurred 28c. Injury at Work? After 5 Panding invastigation 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funerel Director: After completely filled in by the fur 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not ba 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida 1 Cartifying Physician: To the best of my knowladge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner as steted.
2 Medicat Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifiar Medicai 29b. Signatura and titia of certifiar 29c. Licansa number 29d. Data algnad (Month, Day, Year) December 20, 1999 Cynthia Kuttree-Sand no DYTYS Cynth. a Kuttner-Sands no 11110 Medical Campus Road, Suite 130, Hagers town
31. Data filed (Month, Dev. Year) 1999 32. Agistrar's Signature of 30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print) State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) -2. Date of Deeth 3. Time of Death Virginia Doarnberger Mary Month 11:30 Am Dec 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Howard Columbia 5978 Camelback Lane If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) Birthpiece (State or Foreign Country) 1□ M 204 Days Yrs. 214-09-7054 Usual Residence of Decedent 86 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Hagerstown Maryland | Washington 10e. Street end Number 10g. Citizen of What Country? 10f. Zip Code U.S.A. 21742 1145 Beechwood Drive 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) 8 Sales Clerk Clothing Store 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Ruth Cline Unknown 19a. Informant's Name/Reietlonship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Columbia, Md. 21045 5978 Camelback Lane <u>Robert L. Doarnberger - Son</u> 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 12/19/99 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 LiVestal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one ceuse on each line. Approximeta

Physician /Medical Examiner

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Physician

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permit. Peges 1 and 2 should be filed within 72 hours efter deeth with the Merylan Department of Heelih and Mentel Hygiene. Important: if Itam 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examines must be notlined.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760

has certificate

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certific completely filled in by the funeral director,

immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Part il. Other significant conditions contri þ Completed 2 Medical Certification:

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Conger,

DEC 1

29b. Sigpature end title of cartifier

31. Dete filed (Month, Day, Year)

ceuse on each line.	,	interval Between Onset and Death
Lung cancer		(mont
Due to (des a consequence of):		
Due to (or es a consequence of):		
Due to (or as a consequence of):		
buting to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco usa co	ntributa to the cause of death

				1 □ Yes 2 ₾ No	3 Probably 4 Unknow
				24a. Was en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
				1 □ Yes 2 11 No	1 □ Yes 2 2 110
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing I	Home 5 ☐ Residence 6 ☐ Ott	ner (Specity)
27. Manner of Deeth 1 Neturel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury et Work? 1 Yes 2 No	28d. Describe how injury occur	red
3 Suicide 6 Could not b 4 Homlcide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factly)	tory, office	28f. Location (Street and Numb City or Town, State)	ber or Rural Route Number,
				e, and due to the cause(s) end ma urred at the time, date and place,	

29c. License number

State Registrar

DHMH 16 Rev 6/95

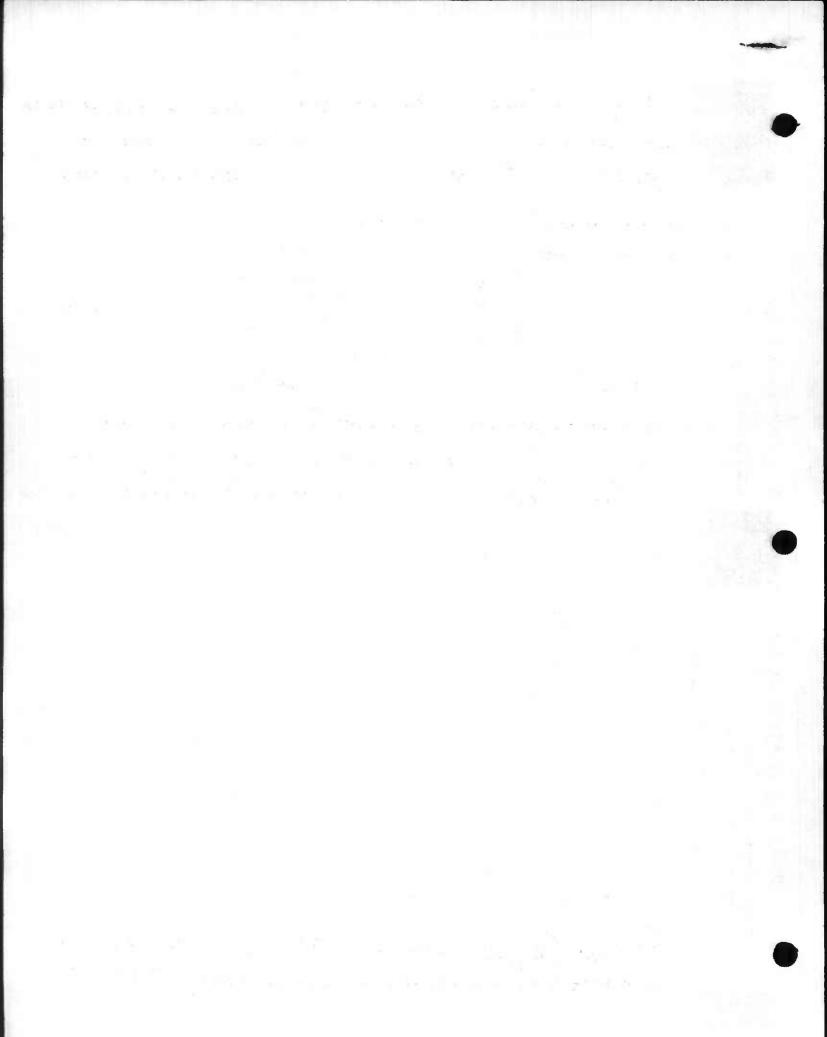
29d. Date signed (Month, Day, Year)

Dec 16, 1995

Ms Sucti 205 (1909, Print)

32. Registrate Streeture

Columbia /



State of Maryland / Department of Health and	The state of the s	S	
Certificate of Death	Reg. No.	99	41551
L+	2. Dete of Deeth Month Day	Year	3. Time of Death

1. Decedent's Name (First, Middle, Last)

Fu Dir

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

Phys /Me

To the Hospital or Attanding Physician: The law requires that the death certificats be associted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division of VItal Records, P.O. Box 68760,

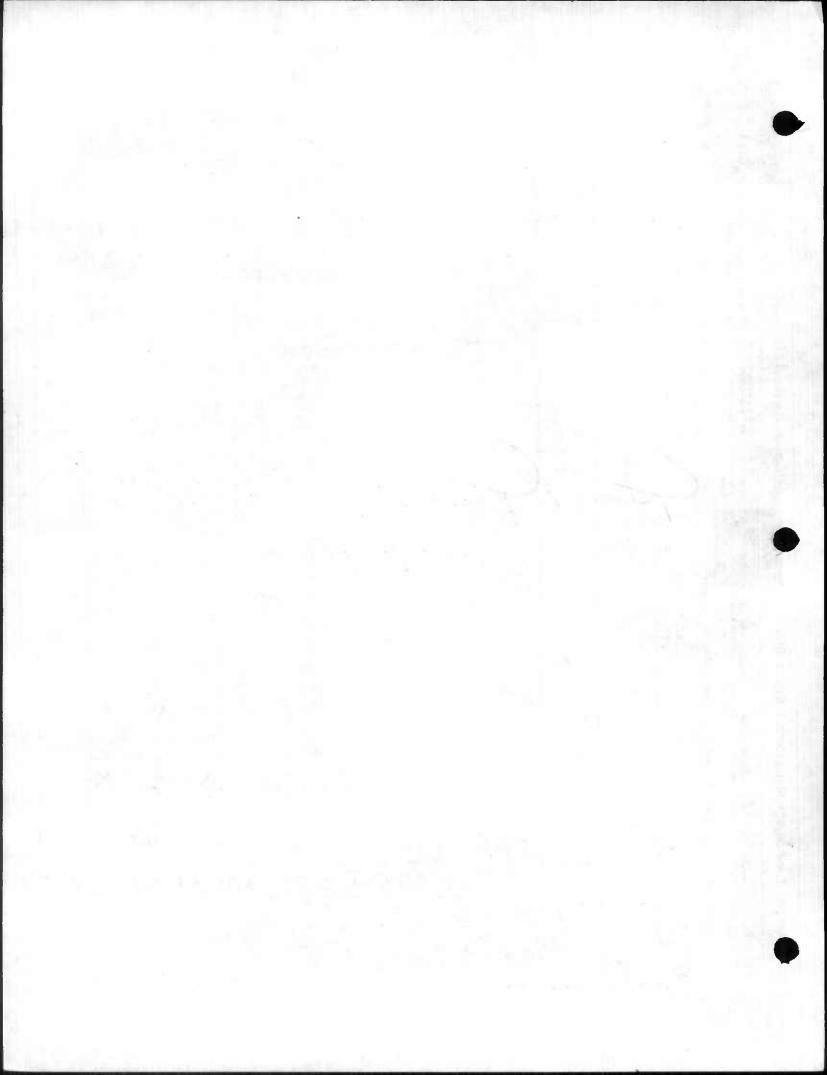
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		n, give street and numi					, or Location of Dee		
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Usual Resider	10b. County		10c. Cit	y, Town or Loc	cation				10d. Inside City Lim
Md.		ington		•	ithsbur	0			1 ♥ Yes 2 □
10e. Street an		znyzon		3110	1			40-000-00-41	
	West Dou	glas Ct.			10f. Zip Cod 21	783		10g. Citizen of 1	.S.A.
	etus Married 2 Merri wed 4 Divorced	If Yes Give	es? No		Vas Decedent of Yes, specify C		? (Specify Yes or Nuerto Rican, etc.)	Ble	e - American Indian, ck, White, etc. v: White
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Elementary 1	/Secondary (0-12)	College (1-4	lor 5+)	8-7-1	Cashi			Dept.	Store
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	d Jesse M						Ruth Tre		
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		Hart (Husb	and)	1			mithsburg		
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1 CKenna	2 Cremetion	3 □Removal from St	nto C	emetery, crem	etory or other	plece)			
-	tion 5 Other (S		Sm				. 13, 199	Smith	sburg, Md.
21. Signature	of Funeral Service	Licensee	1	22.	Name and Ad	dress of Facility	12525 1	Bradbury	Ave.
-	tennes	1	an	c Ba	urs tun	eral Hon	ne Smiths	bura. Md.	21783
Immediate Codisease or coresulting in disease or coresulting in disease. Sequentially if any, leading cause. Enter Cause (Diseasthat initiated etc.)	ndition aeth) ist conditions, g to immediate Underlying se or Injury	b	Dua to (o	or as a consequence as	uence of):	79470	· ·		
resulting in de	ath) Last	d	000 10 (0	as a consequ	ience ory.				
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								s en eutopsy formed?	24b. Were autopsy finding aveilable prior to completion of cause of daath?
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	referred to medical					26. Place of	Death (Check only	one)	
axaminer?	2 No	Hospitel:	patient 2 🗀	ER/Outpatient	AOD WAY	Other:	ng Home 5□Re		ner (Specify)
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4 ☐ Homi	dotorm	ined 288. PIRCE O	I Injury - At ho , etc. (Specif	STL	et, fectory, offi	20	City or To	(Street and Numi own, State)	J Sniffshi
29a. Certifier		g Physician: To the be Examiner: On the basi and manne	is of axaminat						end due to the causa(s)
295. Signatury	and title of certifier	10			29c. Lic	ense number		29d. Date signe	d (Month, Dey, Year)
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State

Registrar

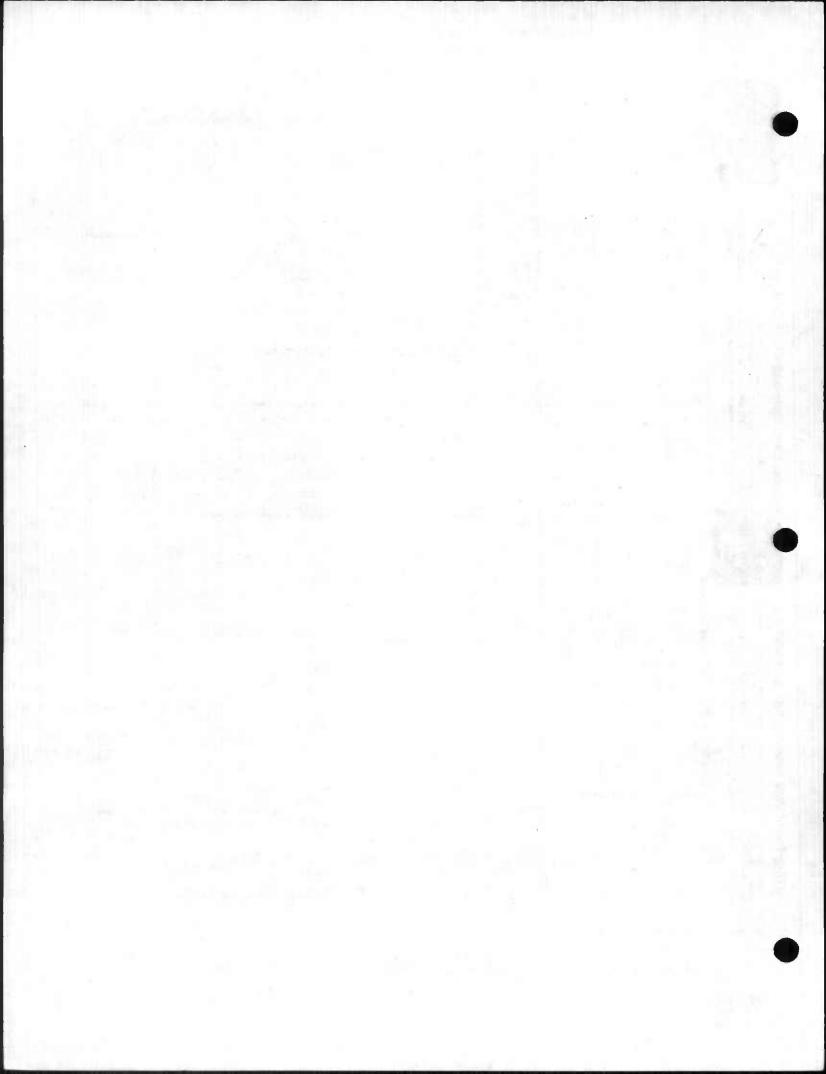
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32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

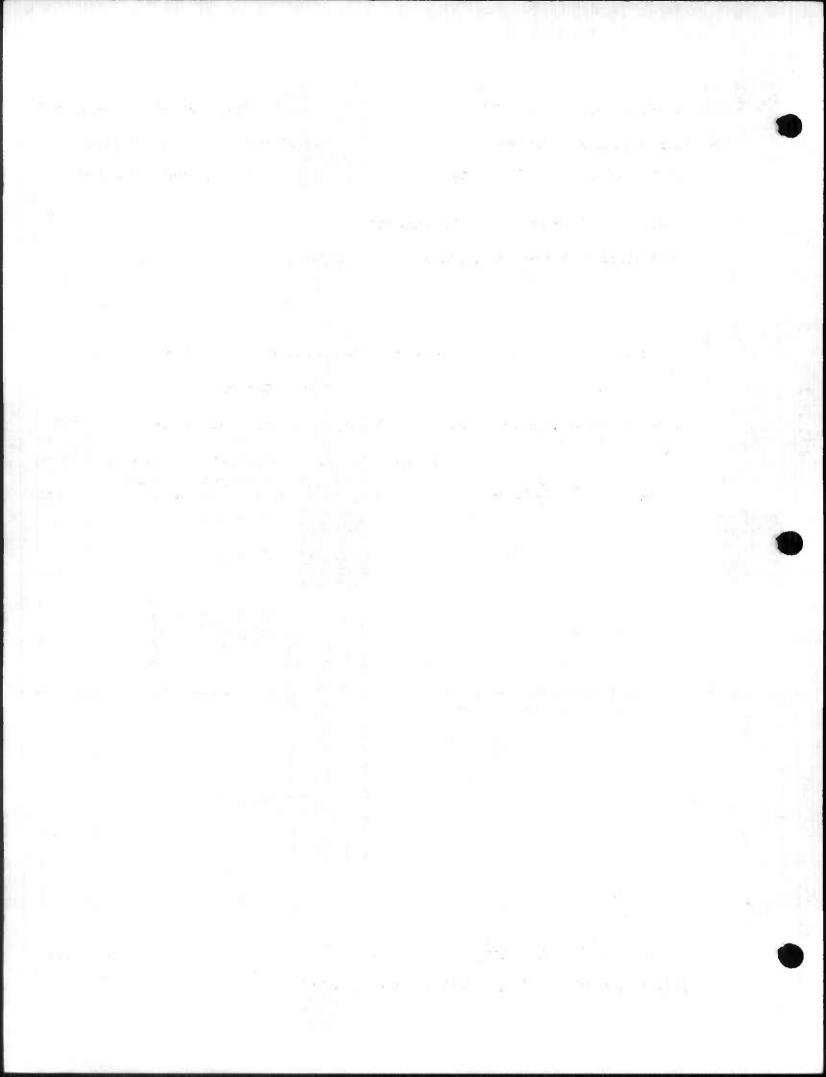
Decedent's Neme (First, Middle, Las) James Edward Ecke Facility Name (If not institution, give 16127 Cloverton Social Security Number 6. Sc 217-28-5536 Suel Residence of Decedent 10b. County Idaryland Washing 10e. Street and Number 6123 Cloverton La 10e. Merital Status 10e. Never Married 2 Married 30e. Widowed 40e. Decedent's Edic (Specify only highest grace) Elementary/Secondary (0-12) 12 12 12 12 13 14 15 16 17 18 16 17 18 18 19 18 19 18 19 18 19 18 19 18 19 18 19 18 19 18 18 19 18 18 19 18 18 18 18 19 18 18 18 18 18 18 18 18 18 18 18 18 18	ert, Sr. street and number) Lane Age (In yrs. 67 10c. Cit Ston 10c. Cit	yrs. ty, Town or Loc is, S. 13. W if 1 16a. Deced (Give I ifie. D Secur	Will 10f. Zip Code 21 Ves Decedent of It Yes, specify Cub Yes, specify Cub Yes 2No Lent's Usual Occul kind of work done NO NOT use retire	iamsport 795 Hispanic Origin? (Span, Mexican, Puerlo Specify: Dation during most of work of) nistrator	PORT 8. Date of Birth (Month, Day, April] 1 ecity Yes or No- Rican, etc.)	Vear) L, 1932 Og. Citizen of Wh USA	shington 9. Birthplace (State or For Country) New York 10d. Inside City L 1 Yes 2 [hat Country? - American Indian, , White, etc. white
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Patricia R. Ecker a. Method of Disposition 1 X Burial 2 Cremetion 3 C	t - wife	10b Mailin		Rit	a Rose S	Shaum	
a. Method of Disposition 1 🗓 Burial 2 🗀 Cremetion 3 🗀		ISD. MORIT	g Address (Street	and Number or Run	al Route Number	, City or Town, S	itate, Zip Code)
1⊠ Burial 2 ☐ Cremetion 3 ☐		161	27 Clove	rton Lane	, Willia	amsport,	Md. 21795
	20b. F	Place of Dispos	sition (Name of netory or other ple	cel	Dete	20c. Location - C	City or Town, State
	Hemovai from State		n Mem. F		-18-99	William	sport, Mary
. Signeture of Funerel Service Licens			. Name end Addre			UNERAL H	
· 7,1	1.1.70	4	15 E. Wi				Md. 21740
3a Part1 Enter the disease or comp	lications that caused the deat	th. Do not ente	ar the mode of dvi	ng such as cardiac	or resoiretory are	net	Approximete
equentially list conditions, any, leading to immediate use. Enter Underlying ause (Disease or injury at initiated events sulting in death) Last	b. Due to (c	or es e consequ	uence of):				
		ulting in the un	nderlying cause gi	ven in Pert I.			iributa to the cause of d
					24a. Wss a perform		24b. Were eutopsy findi available prior to
							completion of caus of death?
					1 🗆 Y	es 20 No	1 ☐ Yes 2 ☐ No
. Was case referred to medical examiner?					h (Check only on	10)	
1 ☐ Yes 2 ☐ No	1 ☐ Inpatient 2 ☐	ER/Outpatient	1 3□ DOA Ot	her: 4 Nursing Ho	me 5 Reside	ence 6 Other	(Specify)
Manner of Death Matural Accident Suicide Homicide Manner of Death Coulding investigation Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Piece of tnjury - At h building, etc. (Specification)	28b. Time of Injury ome, ferm, stre	M 1		28f. Location (S	treet and Number	
e. Certifier Certifying Phy	sician: To the best of my kno	wledge, death	occurred at the ti	me, date and place,	and due to the c	ause(s) and man	ner as stated.
(Check only 2 Medical Exam	iner: On the basis of examine and manner steted.	tion end/or inv	estigation, in my o	opinion, deeth occur	ed at the time, d	ate end place, an	no due to the cause(s)
b Signature and title of certifier	111		29c. Licens	se number	2	9d. Date signed	(Month, Day, Year)
Meden Ll	()	m	02	3623	17	le cent	1-17 16
Name and address of person who o	ompleted cause of death (Item	n 23a) (Type F	Print)	A			~
C . (1/	in had tel	1.	redica	1 (0-1	nel Rel	(len)	ers town !
	32. Registrage Signe	. 0 .		- man	- b 1	-	
niss salta	was case referred to medical examiner? I yes 2 No Manner of Death I yes 2 Accident Suicide G Could not be determined Check only 2 Medical Examiner? Check only 2 Medical Examiner? Signature and title of certifier	was case referred to medical examiner? Was case referred to medical examiner? Death	was case referred to medical examiner? Was case referred to medical examiner? Death Dea	was case referred to medical examiner? Was case referred to medical examiner? Due to (or as a consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner? Due to (or as e consequence of): Was case referred to medical examiner Due to (or as e consequence of): Was case referred to medical examiner Due to (or as e consequence of): Was case referred to medical examiner Due to (or as e consequence of): Was case referred to medical examiner Due to (or as e consequence of): Was ca	was case referred to medical examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DA Was case referred to medical examiner? Was case referred to medical examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DA Was case referred to medical examiner? Hospital: 1 Inpatient 2 EP/Outpatient 3 DA Wanner of Death 1 Inpatient 2 EP/Outpatient 3 DA Wanner of Death 1 Inpatient 2 EP/Outpatient 3 DA Wanner of Death 1 Inpatient 2 EP/Outpatient 3 DA Wanner of Death 1 Inpatient 2 EP/Outpatient 3 DA Wanner of Death 1 Inpatient 2 EP/Outpatient 3 DA Wanner of Death 1 Inpatient 2 EP/Outpatient 3 DA Wanner of Death 1 Inpatient 2 EP/Outpatient 3 DA Wanner of Death 1 Inpatient 2 EP/Outpatient 3 DA Work 2 Inputy at Work 2 Inp	mediate Cause (Final lease or condition sulting in death) Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): The consequence of t	Due to (or as a consequence of): Due to (or as a consequence of):



State of Maryland / Department of Health and Mental Hygiene

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								C	ertifica	te of	Death		Reg. No.			
		HEX.		Decedent's Nama (First, Middla, Last)								Data of Death Month Day Yaar				
/N		Physic		Violet Bernadette FRISENDA								Dec. 20 1999				15 F.M.
		/Medi Examii		4a. Facility Nama (If not institution, give street and number) 4b. City, Town, or							cation of Death 4c. County of Death					
	и	4.0		Williamsport N	urein	o Hon	n e				Williams	nort		Washi	ngton	
	т	Funerai		5. Social Security Number	6. Sex	g Hon		ga (In yrs. last birthday) If Under 1 Yes			If Under 24 Hrs.	8. Date of Bi (Month, D			0	Stata or Foraign
		Director		051-03-4627-A	1 □ M	2⊠ F	89	Yrs.	Months	Days	Hours Min.	Dec 12		N.	Country) ew Yor	
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		n 72 hours after death with the Maryland "natural", or lisms 23s or 28ef show solical Examinet must be notified at	tor	10a. Stata 10b. County	/		10c. Cit	y, Town or	Location						10d. ins	ida City Limits
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	Baltimore,	Departi Departi Importa any inj once		21. Signature of Funarel Service	0 17	,			22. Nama e	nd Addre	ass of Facility Mi	lnnich	Funer	al Ho	me	
	œ	Dep part		Jomes L. Spicer 415 E. Wilson Blvd. Hagerstown, Maryland 21740												
				23a. Pert1. Entar tha diseesa, o	23a. Pert1. Entar tha diseesa, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one cause on each line. Approximate interval Between									ximata		
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DECEN	o	the d	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death				
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Day Samuel Paul FORBES 0403 ecember) 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington If Under 24 Hrs. If Under 1 Year 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Months Hours 1⊠M 2□ F Yrs. 205-09-5242 87 Feb. 12,1912 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Washington Smithsburg 1 Yes 2X No 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21034 Jefferson Boulevard 21783 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, 11 Marital Status Black, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Give 1 ☐ Navar Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced white Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) engineer railroad 8 0 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Merle Charles Forbes Mary Catherine Wingert 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grace E. Forbes - wife 21034 Jefferson Boulevard, Smithsburg, Md. 21785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cramation 3 □ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Cemetery 12-14-99 Scotland, Penna. 22. Name and Address of Facility 21. Signature of Euneral Service License MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediata Causa (Final disease or condition resulting in death) diogenie Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Muorden Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 1NO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1- Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of fnjury 28c. tnjury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

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Pages 1 and 2 ahould be fit ment of Health and Mental H tant: If them 27 is marked off jury or other traumatic even

Department of Important: If any Injury or

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Examiner The lew requires that the deeth certificate be axecuted burial-transit pue Physician/Medical the 65 65 039 ate has been signed by the atterpage 2 should be detached for ð Be Completed this certificate funeral Aftert the

P.O. Box 68760 Records. Medical Certification: To Attending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al filled in by

> State Registrar

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homlcide

(Check only one)

29b. Signatura and titla of certifier

Mood

DEC 1

31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be determined

Mt

32. Registrar's Signature

Dener

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5 1999

28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.

29c. License number

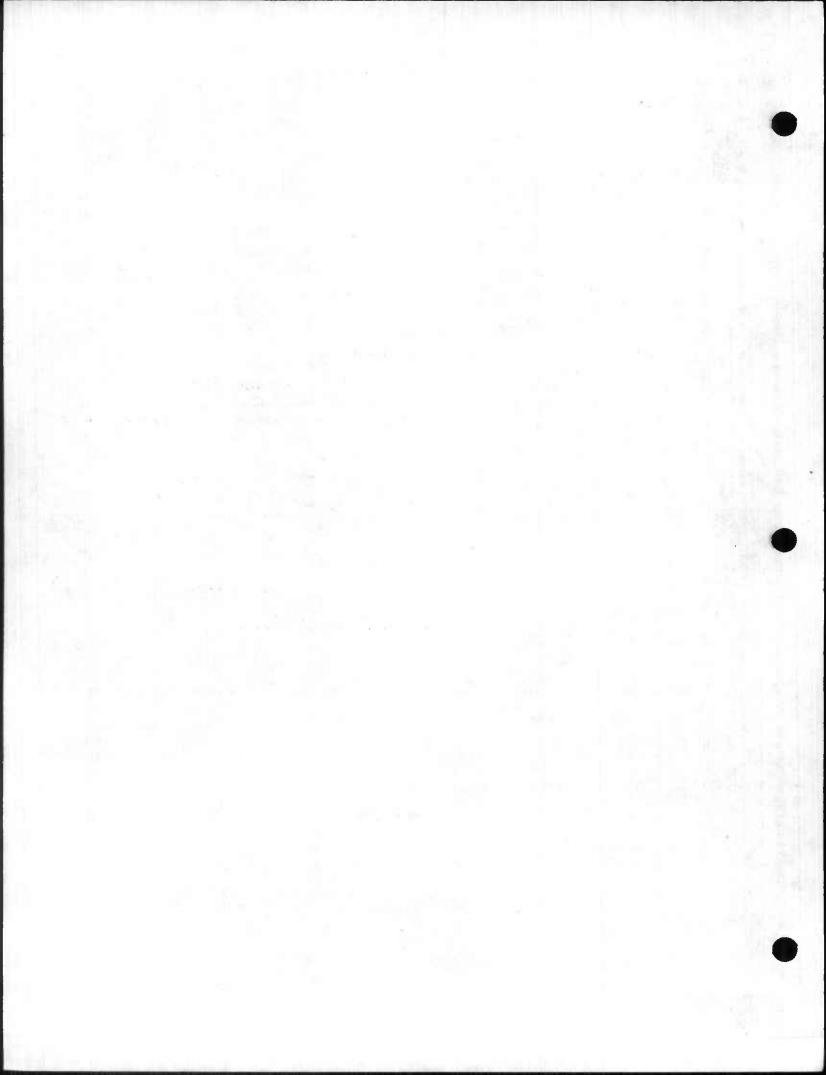
1 Yes 2 No

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print)

Aetna



Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Joseph Franzetti 0200 1)ecamber /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Hagerstown Was
If Under 24 Hrs.
Hours Min.
Hours Min.
January 3, 1914 Washington County Hospital Washington 5. Social Security Number If Under 1 Year Birthplaca (State or Foreign Country)

New York 6. Sex 1 1 M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Yrs. 85 Director 10 7463 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Directo Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b munt be herne 23s 16505 Virginia 21795 Ave. USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Rece - American Indian, Bleck, White, etc. 11. Maritat Stetus Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 ☐ Never Merried 2 ☑ Married "natural", or White 1 Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) accountant Continental Pages 1 and 2 should be filed vent of Health and Mental Hygient: If Nem 27 is marked other t 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Oreste Franzetti Theresa Riccia 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health at Important: If Item 27 is any injury or other trau Judy Khecht Daughter Pilgrim Hollow Rd. New Jersey07712 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 12/13/99 Bronx, N. Y. Woodlawn Cemetery gnature of Funeral Service Licenses 22. Name and Address of Fecility Gerald N. Minnich 305 N. Potomac St. Funeral Home Hagerstown. Maryland 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory erres shock, or heart teilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Finel disease or condition resulting in deeth) Examiner Due to (or agra co Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes VINO 3 Probably 4 Unknown Be Completed by should s 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Wes MP No edical Certification: To 2□ ER/Outpetient 3□ DOA er of Death 28d. Describe how injury occurred 27. Ma 28a. Date of Injury (Month, Day Year) 250. Time of 28c. Injury at Work? After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29e. Certifier completely (Check only one) within 2 29b. Signature an 29c. License number 29d. Dete signed (Month, Dey, Year)

State Registrar didress of person who comple

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31. Dete tiled (Month, Day, Year)

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32. Registrar's Signature

Baltimore, Maryland 21215-0020

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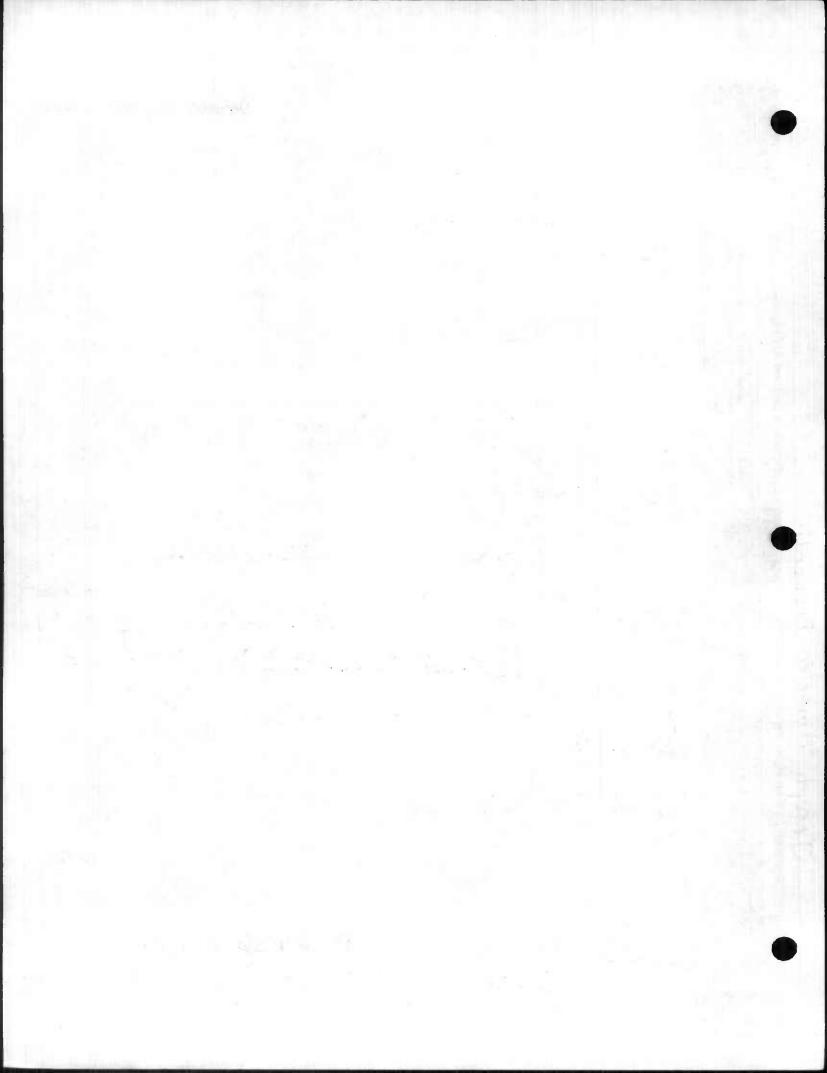
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eth (Item 23a) (Type, Print)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Physician DECEMBER 14, 199 Charles Lee GELWICKS 146 pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Washington If Undar 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Aga (tn vrs. last birthday) If Under 1 Yaar Birthplaca (Stete or Foreign Country) 8. Data of Birth (Month, Day, Year) Funeral Days 1X M 2□ F Months Hours 213-24-9468 69 Director Nov. 12,1930 Maryland Usual Rasidence of Decedant 10a. Stata The Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 11 Yas 2 □ No Director Maryland Washington Hagerstown 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 23a or 21742 1119 Outer Drive USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Was Decedent Evar in U,S. Armed Forcas? Black, Whita, atc filed within 72 hours after 1⊠Yas 2□No 1951 If Yas. Giva 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 ò 1 Yas 2 No Specify: Specify: by white 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: 1955 Completed 15. Decedant's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highast grada complated) (Giva kind of work dona during most of working tife. DO NOT use retired) Hygiene. Elementery/Secondary (0-12) Collega (1-4or 5+) 12 coordinator truck manufacturer 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumema) Be Pages 1 and 2 should be nent of Health and Mental Leon Charles Gelwicks Madelyn Ida McKee 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) of Health of the March 27 le 1119 Outer Dr., Hagerstown, Maryland 21742 June Gelwicks - wife 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 12-18-99 4 ☐ Donation 5 ☐ Othar (Specify) Rest Haven Cemetery Hagerstown, Maryland 21. Signatura of Funeral Sarvice Licensee 22. Nama and Addrass of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md.21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediata Causa (Final disaesa or condition rasulting in death) Examiner Examiner Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Diseese or injury that initiated events rasulting in death) Last Box 68760 Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yee 2 No Be Completed by 24a. Was an autopsy performed? 24b. Ware autopsy findings available prior to available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yas 2 ☐ No Division of Vital 25. Was case referred to made axaminar? 26. Placa of Death (Check only one) Hospitel: Other: 4 ☐ Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) Certification: To 1 Yas 2 1 1 ☐Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA ä 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigetion 1 Natural 1 Tyes 2 No 2 Accident after death Director: 6 Could not be 3 Suicida Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Pleca of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida b To the Hospital within 24 hours a To the Funeral D 1 Certifying Phyeician: To the best of my knowledga, deeth occurred at the tima, data and place, and due to the cause(s) and maintenance. On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, date end place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and titla of certifiar 30. Neme and addrass of person who completed causa of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

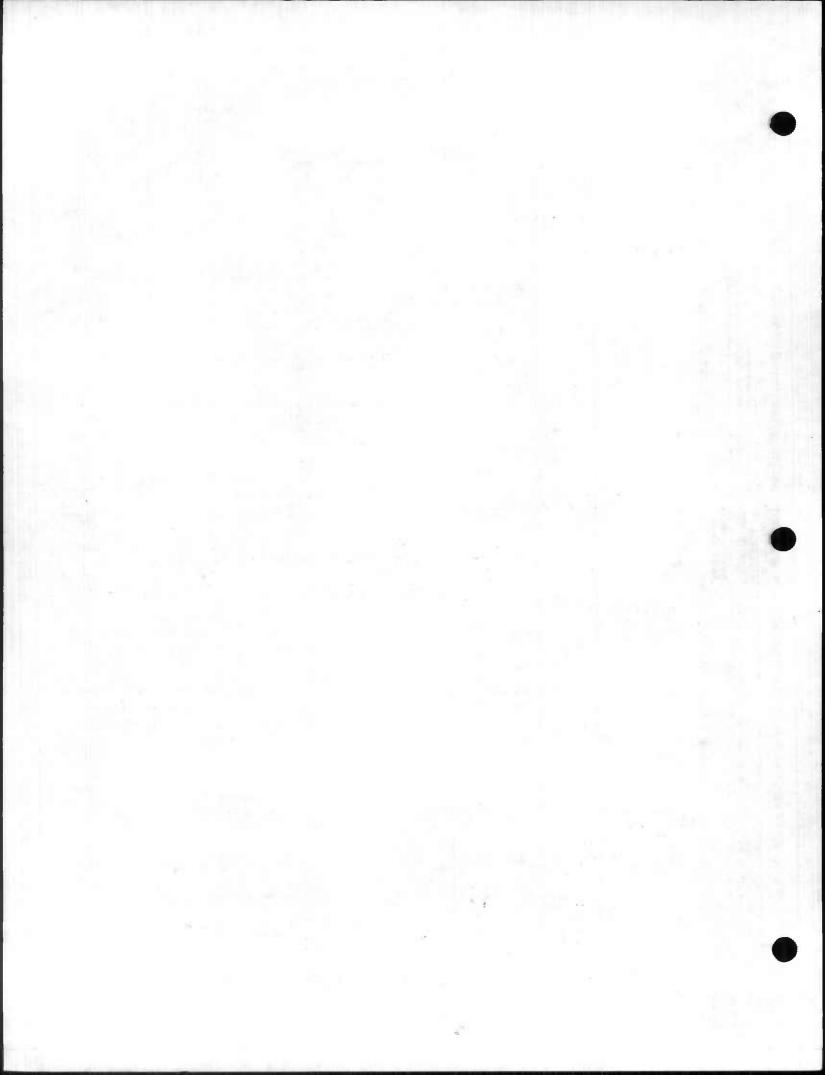
Registrar

31. Data filed (Month, Day, Year)

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32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Death

Physician /Medical	George Forgan HO	LLOWAY				DECEM	BER 21,	1999 8:55 PM			
Examiner	4e Fecility Neme (If not Institution, g					n, or Location of De					
	RAVENWOOD LUTHE 5. Social Security Number 6.			thday) If Under 1		RSTOWN		HINGTON			
Funeral Director	214-09-3534	-W	(In yrs. last bin		Days Hours	Min. (Month,	Day, Year) 24,1912	9. Birthplace (Stata or Foreign Country) Pennsylvania			
of show fied at tor	Usual Rasidence of Decedent 10a. Stata 10b. County	1	10c. City, Town	n or Location				10d. Inside City Limits			
or 28a-f show be notified at Director	Maryland Washin			lagerstown	n			1⊠ Yes 2 □ No			
k no	10e. Street and Number			10f. Zip C	code		10g. Citizen of	What Country?			
	633 Summit Aven	ue			21740		US	A			
Examiner must be by Funeral Di	11. Maritel Stetus 1 Nevar Marriad 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:	-	13. Was Decede If Yes, specif	nt of Hispanic Origin y Cuban, Mexican, I I No Specify:	n? (Specify Yes or I Puarto Rican, atc.)	No- 14. Rac Bla Specifi	e - American Indian, ck, Whita, etc. y: white			
Completed	15. Decedent's ((Specify only highast g	Education trada completed)	16a.	Decedent's Usual (Giva kind of work	Occupation done during most of retired)	of working	16b. Kind of B	usiness/Industry			
the Ma	Elemantary/Secondary (0-12)	Collega (1-4or 5+))	wner/ope			boats				
	17. Fathar's Nama (First, Middle, Las		1 0	er/ope	7	s Name (First, Midd	fle, Maiden Suman	na)			
o Be	George Holloway		Margaret Skinner								
. 5	19a. Informant's Neme/Ralationship	(Type, Print)	19b	. Meiling Address (Street and Number	or Rural Routa Nun	nber, City or Town,	Stata, Zip Code)			
Traumatic To	19a. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Nina Mae Holloway – wife 633 Summit Ave., Hagerstown, Maryland 21740										
đ.	20a. Mathod of Disposition	y will	20b. Place of	Disposition (Name	of	Data		City or Town, Stata			
and injury or other trau	1 ☑ Buriel 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Spec		cemater	ry, cremetory or oth Hill Ceme	er plece)			own, Maryland			
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any any	+ costn	Minne	ul	,		LITITITIT		Md. 21740			
	23a. Part1. Entar tha diseese, or con shock, or heart feilure. List onl	mplications that caused the	ha death. Do r	not entar tha mode	of dying, such as ca	ardiac or respiretory	r errest,	Approximate Interval Between			
ician dical	Immediate Cause /Final							Onset and Death			
iner	Immediate Cause (Final disease or condition resulting in death)	a Acute Lef	t Lower	r Lobe Pn	eumonia			4 DAYS			
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ial-transit	Sequentially list conditions,	Di	ua to (or as a	consequence of):							
	Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarlying Cause (Disease or injury										
lca lca	that initiated events rasulting in death) Last	C. Du	ua to (or as a c	consequence of):							
attending prysolan and for use as the bunki-transit clan/Medical Examir											
Sen Z		d						1			
2 -	Part II. Other significant conditions	contributing to death but	not resulting in	n the underlying cau	use given in Pert I.	23b. D	ld tobacco use co	ntribute to the cause of death?			
Phys								3 Probably 4 Unknow			
be det	Previous Cerebra	1 Infarction	n with	Dementia	,	'					
eted eted	Undernutrition,	Dehydration	, Atria	al Fibril	lation,		es an autopsy vrlormed?	24b. Were autopsy findings available prior to completion of cause			
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o o	25. Was casa rafarrad to medical				26 Place	of Death (Check on					
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3. Time of Death

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 1 Yas 2 No 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of certifian 29c. License number dery/ fue

29d. Data signed (Month, Day, Year)

D07857 DECEMBER 23, 1999

30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

Dr. Edson B. Moody, 1190 Mt. Aetna Rd., Hagerstown, Md. 21740

State Registrar

Certification: To

Medical

3 Suicida

29a. Certifiar (Check only one)

4 Homicida

31. Data filed (Month, Day, Year) DEC 2 3

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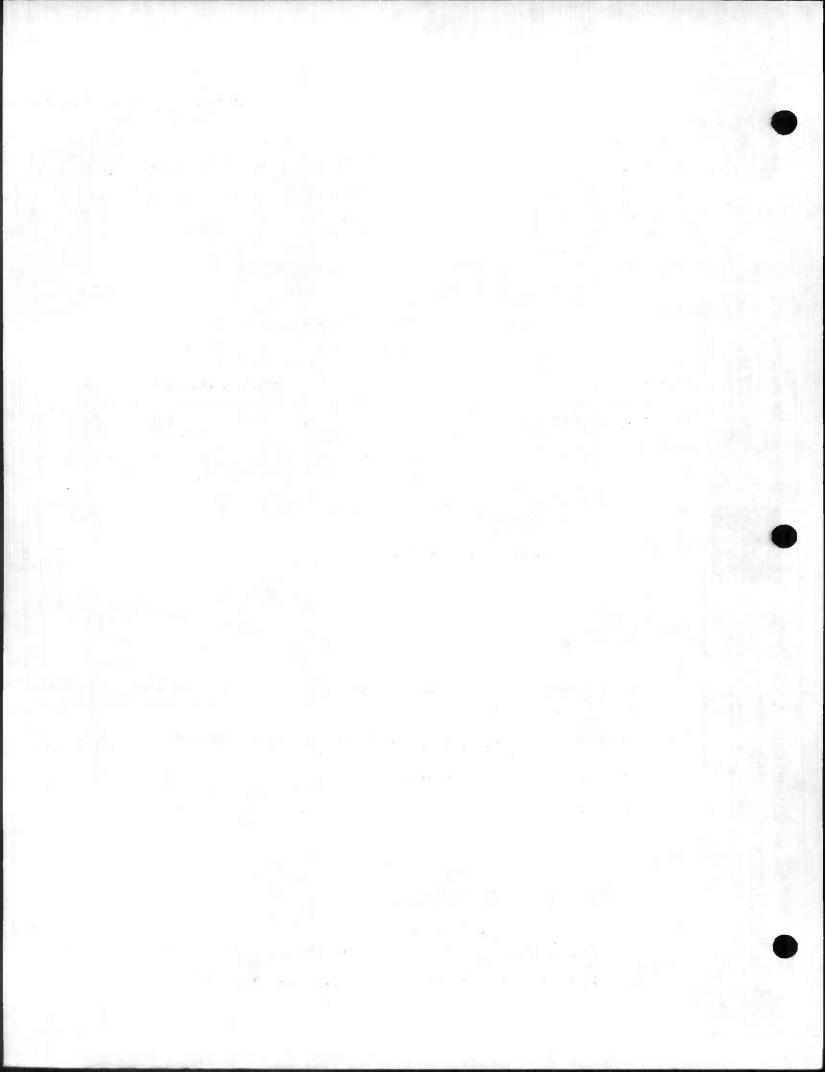
32. Registrar's Signature

Division of Vital or Attending Physician:

ne Hospital or Attending no 24 hours after death.

within 2

filled in by



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month ROBERT **EMLEN HESS** DECEMBER 18, 1999 12:45 AM 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 117 TEMPLE STREET SECRETARY DORCHESTER 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 9. Birthplece (State or Foreign Country) NEW JERSEY 7. Age (In yrs. last birthdey) M 2□ F Months Deys Hours 214-10-5771 Yrs. 87 Usuel Residenca of Decedent 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1X Yes 2 No MARYLAND DORCHESTER SECRETARY 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 117 TEMPLE STREET USA 21664 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No. If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Merital Stetus 1 Never Merried 2 X Married 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) ADMINISTRATOR EDUCATION 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) MICHAEL EMLEN HESS ELIZABETH AMALIA WOLFE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MARGARET E. HESS/WIFE P. O. BOX 67, SECRETARY, MARYLAND 21664 20b. Plece of Disposition (Neme of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 12/19/99 CAMBRIDGE, MARYLAND 4 Dona CAMBRIDGE CREMATORY 22. Name and Address of Fecility
ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, and only one cause on each line. Approximete Intervel Between Onset and Death Heart failere. Immediate Cause (Final money disease or condition resulting in death) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes en eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? 2 1 No 1 Yes 1 ☐ Yes 2 No 26. Piece of Deeth (Check only one)

Examiner certificate be exec Box 68760 2 P.O. signed d be de Records, Completed 5 eded Division of Vital Certification: To this Affe Attending death safter death E

b

To the

within 24 hours a To the Funeral D Hospital

Physician

/Medical

Examiner

Funeral

Director

25a-f show must be notified at

8

thems 23a

'natural', or

Hygiene.

permit, Pages 1 and 2 should be i Department of Health and Mental i Important: If Item 27 is marked or

Physician

/Medical

Pages 1 and 2 should

filed within 72 hours after

altimore. Maryland 21215-0020

Director

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Be

Examir

Physician/Medical

þ

Be

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred Natural 5 ☐ Pending investigation ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es stated.

Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end placa, end due to the ceuse(s) end menner steted. /Check anty 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

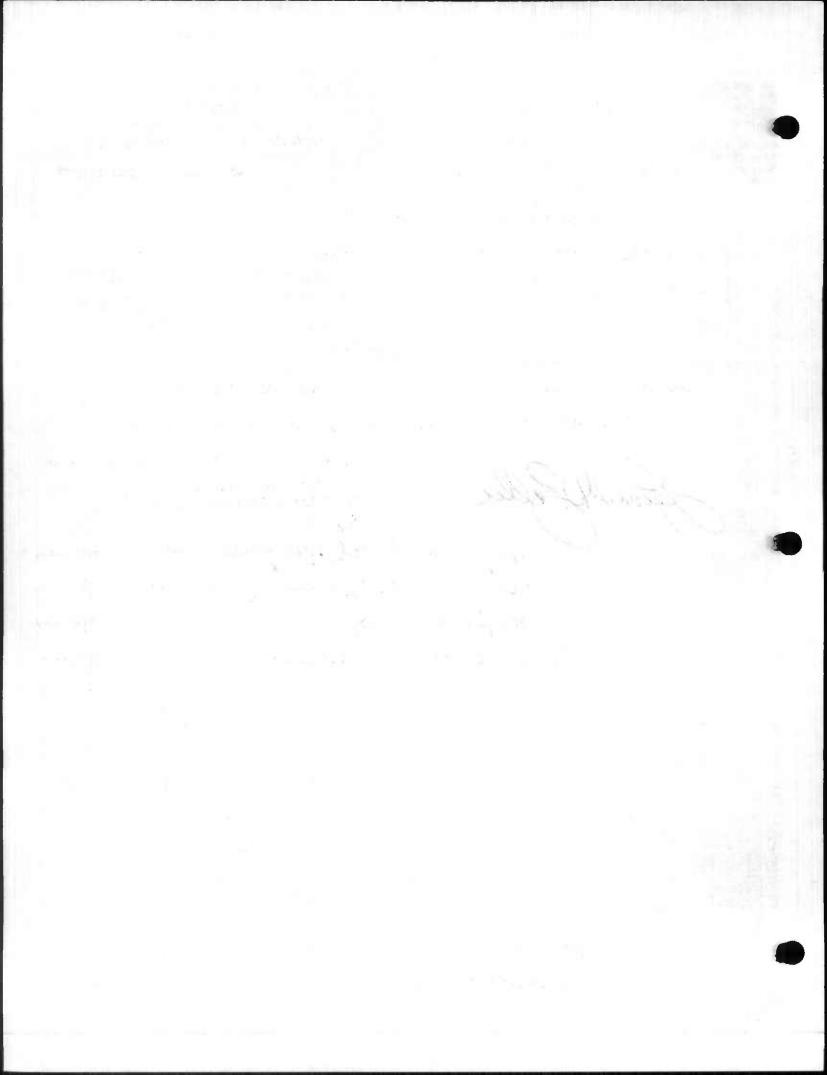
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30. Name and address of at

AHMED NAWAZ 32. Registrar's Signeture Jener

mpleted cause of deeth (Item 23e) (Type, Print)

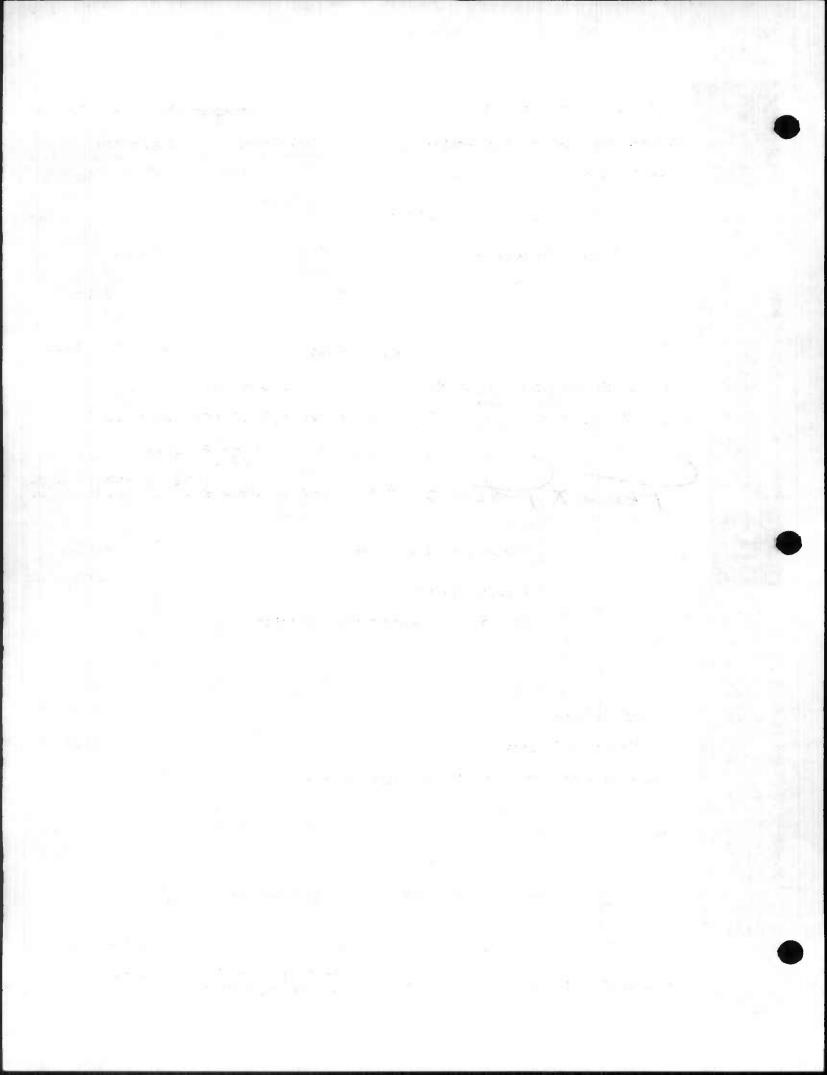
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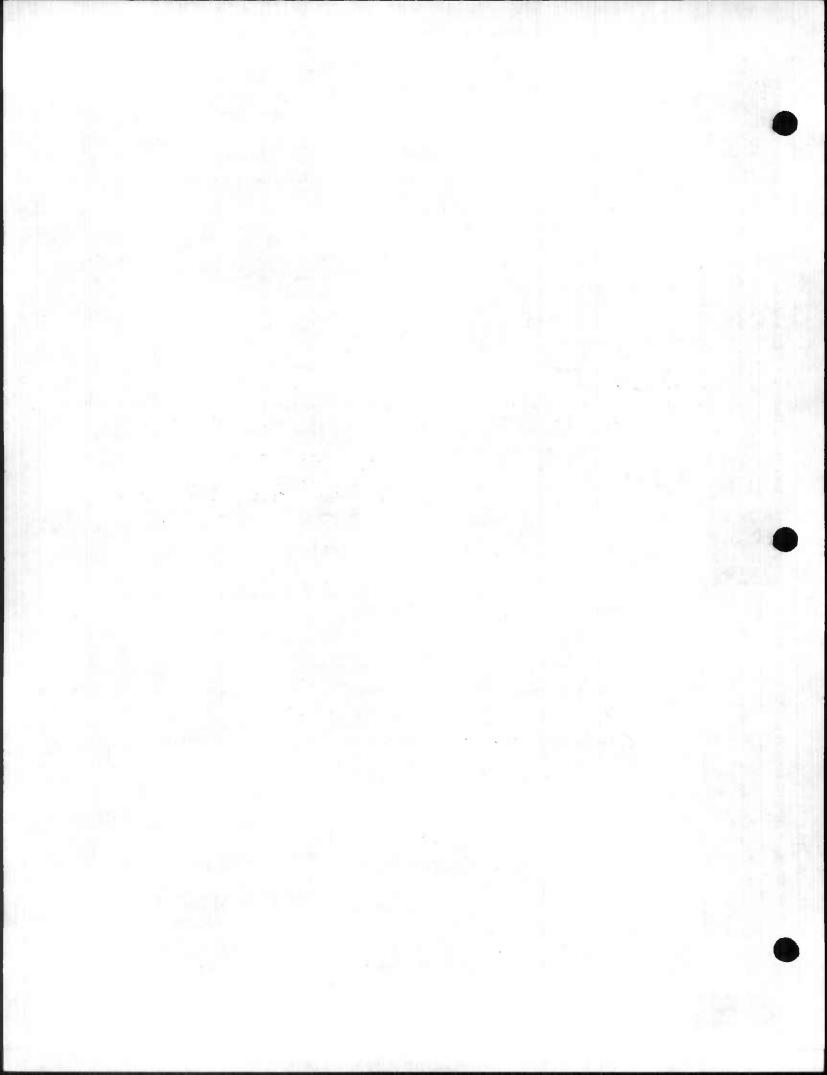
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8	Funeral Director		214-30-6359	Sex 7. Age	e (In yrs. last birt	thday) If Under 1 Months E	Hagersto Year If Under 24 Hrs Days Hours Min	8. Date of Birth	Washi (Year) (1933	ngton 9. Birthplace Country) Mary	e (Stete or Foreign Land
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				104	Inside City Limits
	Manyl f sho	0	Md. Frede	rick		ferson					1 ☐ Yes 2 🛣No
	28a-	rect	10e. Street and Number			10f, Zip Co	ode		I Og. Citizen of V	Whet Country'	7
	h with	a D	1333 Arnolds	town, Rd.			21755		U.S	_	
21215-0020	72 hours efter death with the Manyand natural; or items 23a or 28a-f show pred Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent II Armed Forces? 1 2 Yes 2 1 N If Yes, Give Year or Dates:	56-64	13. Was Deceden If Yes, specify 1 Yes 2 2	t of Hispanlc Origin? (S Cuben, Mexicen, Puer [No Specify:	Specify Yes or No- to Ricen, etc.)		e - American I ck, White, etc.	
5-0	72 ho	eted	15. Decedent's E (Specify only highest gr		16a.	Decedent's Usual C	Occupation	nekina	16b. Kind of Bu	usiness/indust	Iry
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12	e filed within Il Hygiene. other than vent, the M			- 4		Consult					agement
Maryland	od oth	Be	17. Father's Name (First, Middle, Last		~ ~ ~			ie Bori		10)	
2	d 2 should be th end Mental 7 Is merked of traumatic ev	70	Roger Smith 19a. Informant's Name/Relationship (- 1	Mailine Address (C	treet and Number or R			0-6 7-0	4-1
	12 he tra		Virginia T. He				dstown, R				
Baltimore,	permit. Pages 1 and 2 Department of Heelth Important: If Item 27 II any Injury or other tre once.		20a. Method of Disposition 1 Huml 2 X Cremation 3 □ 4 □ Docation 5 □ Other (Specil		cemeter	Disposition (Name y, crematory or othe Sburg Cr	of rplace) cematory	Dec. 18,	20c. Location -	City or Town,	
ati	mit. Poortar	(21. Signature of Runoral Ontvice Lice	(904)	1	22. Name and A	Address of Fecility		525 B	radhui	ry Ave.
B	Demi Depar Impor any Ir		Pennis X	· par			Funeral	Home Sm	ithsbu	urg,Mo	d.21783
	Physician /		23a. Part1. Enter the disease, or com shock, or heert failure. List only	one cause on each lin	е.		r dying, such es cardia	ic or respiretory arr	est,	Inte On	pproximete terval Between nset and Death
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lon	Attending in death. Cotor: After by the fune	tior	1 Naturel 5 Pending 2 Accident investigation	(Month, Dey		njury M	Injury at Work? 1 Yes 2 No		,,		
Division	or Attending of the death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not b	28e. Piece of Inju		m, street, factory, o	ffice	28f. Location (S	treet and Numb	er or Rural Ro	oute Number,
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	To the Hospital or Attending I within 24 hours effer death. To the Funeral Director: Affer completely filled in by the funer	edicai	29a. Certifier (Check only one)	yeician: To the best of niner: On the besis of and manner state	examination and	death occurred et t	he time, dete and plec my opinion, death occ	e, end due to the c urred at the time, o	ause(s) and ma late and place,	inner as state and due to the	d. e ceuse(s)
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			photo	m 1	**	D34	165	D	ecember	17th,	1999
			30. Name and address of person who	completed cause of de	eth (Item 23e) (Typa, Print)	stern Maryl	and Hoos	ital C-	ntor	
			Mohammed S. Ali.		00 Penns	ylvania /	venue, Hag	gerstown.	MD 21	742	
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Month **Physician** James Allen Hathaway December 16, 1999 cation of Death 4c. Country of Death 12:12 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplece (Stete or Foraign Country) March 16,1929 West Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Montha Days 1⊠M 2□ F 70 Yrs. 232-42-6595 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington Co. Maugansville 1 Yes 2 No Director 288-f 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ò 13923 Greenfield Avenue Nema 23a 21767 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Rece - American Indien, 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. hours after 1 Never Married 2 Merried 1 XYes 2 No 24/48
If Yes, Give 8/24/48
Year or Dates: 6/19/52 b White altimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementery/Secondary (0-12) College (1-4or 5+) Supervisor 12 0 Construction 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumema) Be Pages 1 and 2 should be nent of Health and Mental marked c Allen Hathaway Elizabeth Williams 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) ž Department of Health a Important: If Item 27 is any injury or other tra Beverly A. Hathaway/Wife 13923 Greenfield Ave., Maugansville, MD 21767 20a. Mathod of Disposition 20b. Piece of Disposition (Nama of 20c. Location - City or Town, State cemetery, cremetory or other place) 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Cedar Lawn Memorial Park Dec. 20 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Fecility
Douglas A. Fiery Funeral Home
1331 Eastern Blvd.N., Hagerstown, Maryland 21742 21. Signature of Funerel Service Licenses wellow A. Finis 23a. Part1. Enter the disease, or complications that gaused the death. Do not enter the mode of dying, such as cardiac or raspiretory errest, shock, or haad failure. List only one cause or sech line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Dua to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initioted events resulting in death) Last enve Physician/Medical Due to (or as a consequence of): neumono Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown with me pastists þ 24b. Were autopsy tindings eveilable prior to Completed 24a. Was an autopsy performed? completion of cause of death? Mu 1 Yes 2 No 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Impatient 1 Yes 2 LN Certification: To 2 ER/Outpatient 3 DOA 27. Manneg of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 1 PNatural 5 Pending 1 Tyes 2 No death. investigation 2 Accident 24 hours after deat Puneral Director: 6 Could not be 28t. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 Suicide 28e. Placa of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 4 Homicide ò filled in Hospital 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and mannar stated. 29a. Certifier edical compiately (Check only one) within 2 å 29d. Dete signed (Month, Day, Year) 29b. Signature anglittle of certifier 29c. License number M.D. 30. Name and address of person who completed bause of deeth (Item 23s) (Type, Print) L. COPPECES eno M-D 31. Date filed (Month, Day, Year) DEC 1 7 1999 32. Registrar's Signeture State Registrar

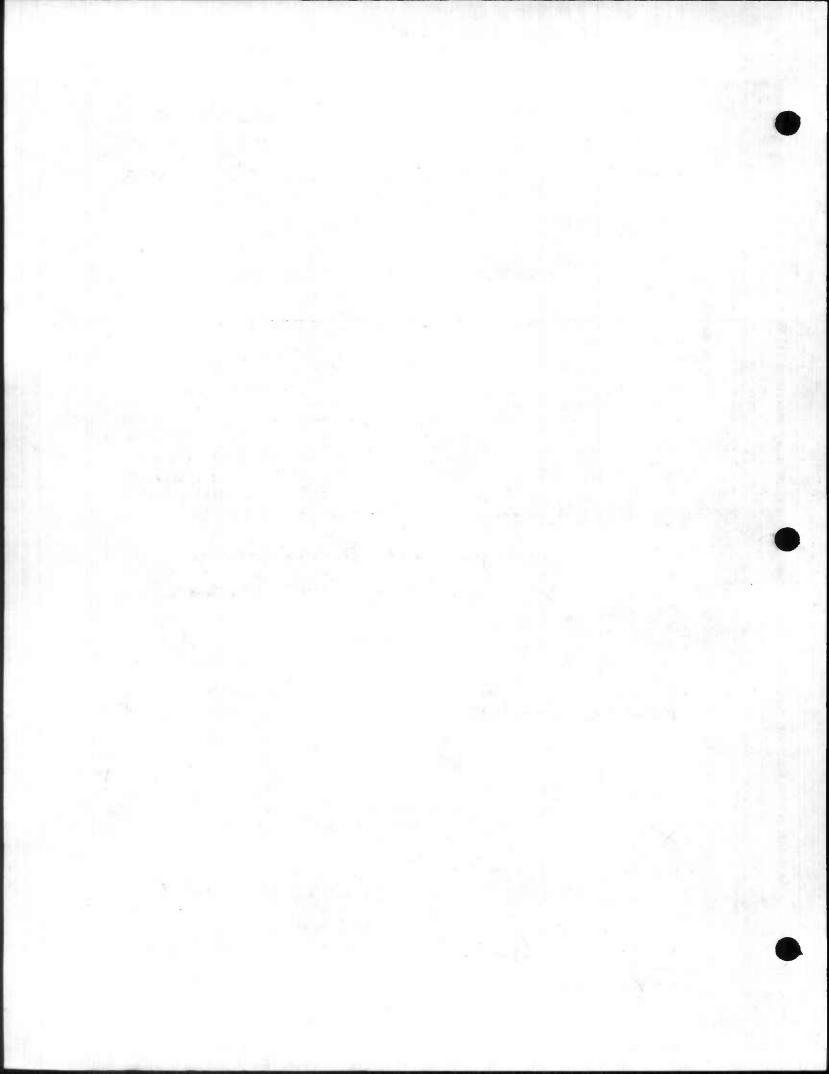


State of Maryland / Dep

partment of Health and Mental Hyglen	e	1	
ertificate of Death Reg. No.	0.		

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ECKER					Certificate	e of	Death	7		Reg. No.	. 1	1001
		1. Decedent's Nama (First, Middle,	Last)						2. Date of D		Year	3. Time of Death
Physici /Medic		Paul Leon HECKE	R. Sr.							Day IBER 14.		18:30 PM
Examin		4e Facility Name (If not institution,		or)		T	4b. City, To	own, or L	ocation of Dea	th 4c. Count		
E Admin		413 RIDGE AVEN	म				Нао	erst	own	WASH	INGTO	N
Funeral				Age (In yrs. last bin	hday) If Under		If Under	r 24 Hrs.	2 Date of B	ieth		place (State or Foreign
Funeral Director		217-09-9658	1⊠M 2□F		rs. Months	Deys	Hours	Min.	(Month, D	18 1916	Cou	ntry) yland
		Usual Residence of Decedent		83				1	Whiti	10 1910	Hal	yland
of Bu	ı	10s. State 10b. County		10c. City, Town	or Location							10d. Inside City Limita
Ve 4 and	0	Maryland Washi	naton	н	agerstow	n					1	1 Yes 2 No
2 29	8	10e. Street and Number	ingcon	11.	10f. Zip					10g. Citizen of	What Cou	ntn/?
20 re after death with the Maryland r, or thems 23e or 28e-f show saminer must be notified at	Funeral Director				101. 24	0000	017/	^				,
6 27	2	413 Ridge Avenu		A. F	140 W D		2174			U.S.		ees Indias
P P	5	11. Marital Status	12. Was Deceder Armed Forces	5?	13. Waa Deced If Yas, spec	eni or ify Cut	pan, Mexica	ngin / (Sp in, Puarto	Rican, etc.)	Bis	ck, White,	can Indien, atc.
1215-0020 within 72 hours sha ens. then *netural, or in the Medical Examina	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give		1 ☐ Yes 2	No No	Specify	<i>r</i> :		Speci	y: TTh	4 4
21215-0020 d within 72 hours an giens. rr then "netural, or the Madrel Essen	P		Year or Dates	1111 22								ite
72 22	Completed	15. Decedent'a (Specify only highest)		16a.	Decedent's Usua (Give kind of wor	k done	during mos	st of worl	king	16b. Kind of E	lusiness/In	dustry
전 를 등	급	Elementary/Secondary (0-12)	College (1-4o		'life. DO NOT us							
d 2	8	8	0		Dock Wor	ker				Trucki		mpany
aryland 212: should be filed within nd Mental Hygiena. marked other than imatic event, the M	å	17. Father's Name (First, Middle, La	st)				18. Moth	er's Nem	e (First, Middl	e, Maiden Suma	me)	
Vian Suld be Mental Mental	9	Daniel Hecker					Mar	y De	vona We	eaver		
Maryland d 2 should be flie th and Mental Hy 7 Is merked other traumatic event		19a. Informant's Name/Relationship	(Type, Print)	19b	Meiting Address	(Stree	t and Numb	per or Ru	ral Route Num	ber, City or Town	, State, Zi	Code)
1 and 2 1 and 2 Health a m 27 la		Paul Hecker, Jr	•	1	7542 Swa	nn	Road	Hag	erstown	n, Maryl	and 2	21740
Baltimore, Maryland 212 somit. Pages 1 and 2 should be flied with Department of Health and Mintal Hygiena. Important: if item 27 is marked other than any injury or other traumatic event, the Marse.		20a. Method of Disposition		comoto	Disposition (Namy, crematory or of	ne of	aca)		Dete	20c. Location	- City or T	own, Stete
Pages nent of nt: if its ny or o		1 □XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		10	Haven C			112	/18/99	Hagers	town	, Maryland
Baltim	ŀ	21. Signature of Funeral Service Lic		Kest	22, Nama and					Funeral		
Bait.		1	1 / /					- L1				
		23a. Part1. Enter the disease, or co	Vistal							erstown,	Ma.	21/40
requires that the death certificate be executed requires that the death certificate be executed the strending physician and should be detached for use as the burial-transit	an/Medical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as e		-0-	ler	- 1	lent Disea	ise.	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
O. H. dear	Physician/	Part II Other significant conditions	contributing to death	but not resulting in	the underlying ca	ause g	iven in Pert	I.	23b. Die	d tobacco usa c	ontribute 1	to the cause of death?
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the the	by	11019	11 - CVIL	112							1	
Records, ne law requires the e has been signe oge 2 should be	8								24a. Wa	s an autopsy formed?	24b. W	Vere autopsy findings veilable prior to
law re	9										C	ompletion of causa f death?
The law	Completed								Ne	Yes 2□No	1	Yes 2□ No
		25. Was case referred to medical					26 Plan	e of Dog	th (Check only			1
Of Vita Physician: this certifical	o Be	axaminer? 1 - Yes 2 - No	Hospital:	tient 2 ER/Ou	tpatient 3 DO	. 0	thor:			sidence 6 🗆 Ot	har /Cnac	(A.)
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isi dea ctor y the	5	3 Suicide 6 Could no	be one Diese of I	njury - At home, fe	m street fectory	office			28f. Location	(Street and Num	ber or Rui	ral Route Number,
Division or Attendi	E	4 ☐ Homicide determine		elc. (Specify)	, 6.0001, 1001019	, 0,,,,,				own, State)		
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Hospital 24 hours Funeral staly filled	edical		Physician: To the bes aminer: On the besis	of examination and	for investigation,	in my	opinion, de	eth occur	red et the time	e cause(s) and m	and due	to the cause(s)
DIVISION To the Hospital or Attendaming Within 24 hours after death to the Funeral Director: completely filled in by the	Š	29b. Significate and title of certifier	and manner :	Stateo.	290	Licen	se number			29d. Dete sign	ed /Month	Dev Year)
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	- [Hunt	preo	W		OCI	-1C				JEIN T	J, 1799
	- 1	30 Name and address of person with	o completed cause of	death (Item 23a)	Type, Print)	٠, ـ	- d) n] ±		Marrelan	212	01
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Sta		31. Date filed (Month, Day, Year)	32. Regis	strar's Signeture	- /-	1						
Registr	ar	DEC 1	ן פככו	- Partie	P. p.	100	uks/					
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** Lorraine Audrey Heinecker December 12, 1999 6:25 P.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 5825 Rowland Hill Rd. Cascade If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Aug. 17, 1919 If Under 1 Year 9. Birthplace (State or Foreign Gountry) 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Days Hours 1□M 2/□F Months 215-03-9244 80 Yrs. Maryland Director Usual Rasidance of Decedant the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic avant, the Madical Examples must be notified at Md. Frederick Cascade 1 Yas 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21719 U.S.A. 5825 Rowland Hill Rd. Funeral death 12. Was Decedent Evar in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11 Marital Status Armed Forcas?

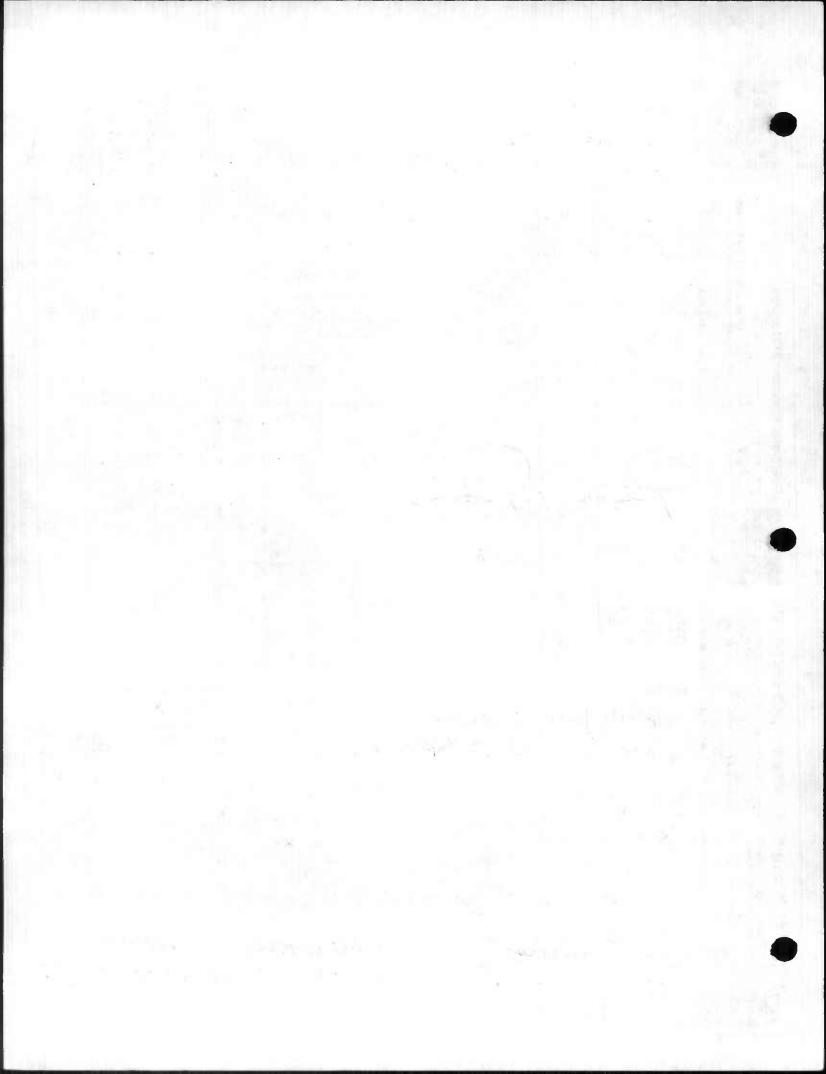
1 Yas 2 No
If Yas, Giva
Yaar or Datas: 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yas 2 No Specify: Specify: White 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event the Market. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 10 18. Mother's Neme (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Be Evelyn Marie Lehn George Joseph Allers 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Ralationship (Type, Print) Deborah M. Heinecker (Daughter) 5825 Rowland Hill Rd. Cascade, Md. 21719 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Dec. 16 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramova from State Meadowridge Memorial Park 1999 Elkridge, Md. 21. Signatura of Funarai Sarvice Licensee 22. Nama and Addrass of Facility Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Md. 21783 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final CVK disaasa or condition rasulting in death) Examiner Dua to (or as a consequence of) burial-transit Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated avants rasulting in death) Last and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical the Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 00 3 Probably 4 Unknown Multurfavet dementia p 24b. Wera autopsy findings aveilable prior to completion of cause of death? B hip frature 24a. Was an autopsy performed? Completed peen s certificate 1 Yes 2 No 1 Yas 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Was casa rafarred to medical examinar? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mannar of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 2 Accident 5 Panding invastigation 1 Yas 2 No 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of fnjury - At homa, farm, street, factory, office building, atc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifiai (Check only one) 29b. Signatura and titie of cartifiar, 29c. License number 29d. Data signed (Month, Day, Year) 12/14/99 MD040452E 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

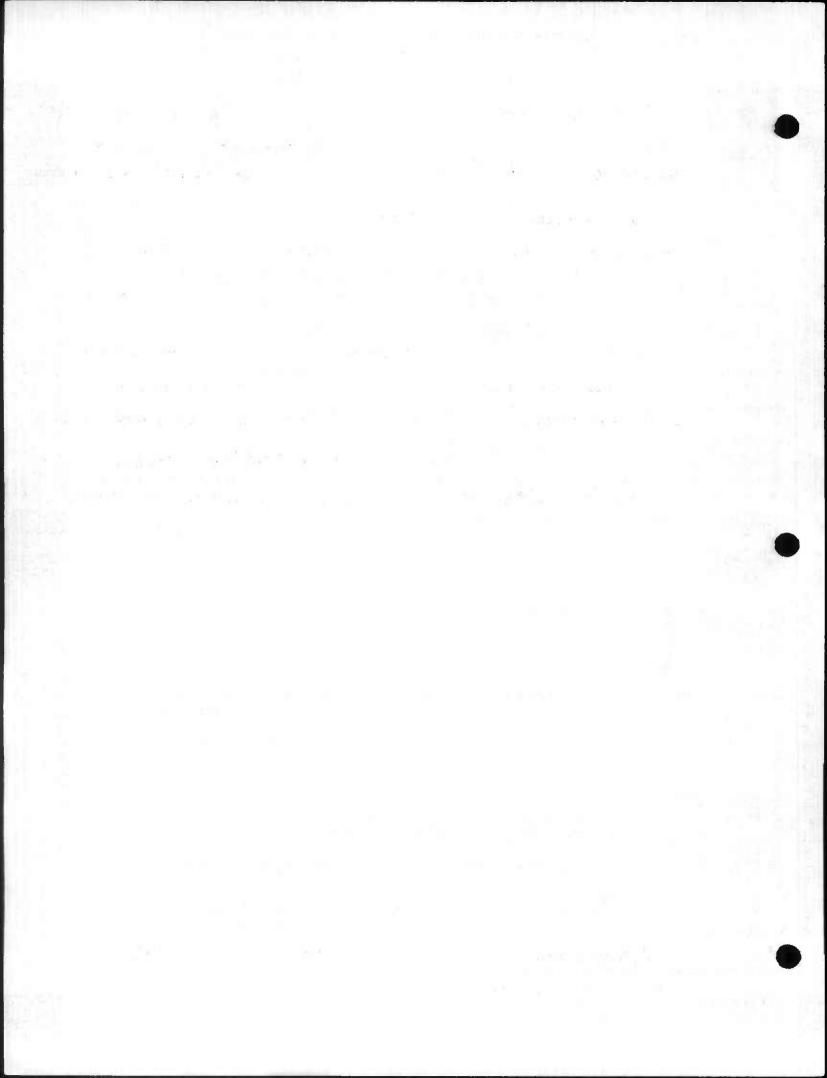
Garrett H. Blanchet M.D. 6155 Anthony Highway, Mont Alto, PA 17237 31. Data filed (Month, Day, Year) 32. Registrar's Signetura State DEC 1 5 1999 souls Registrar

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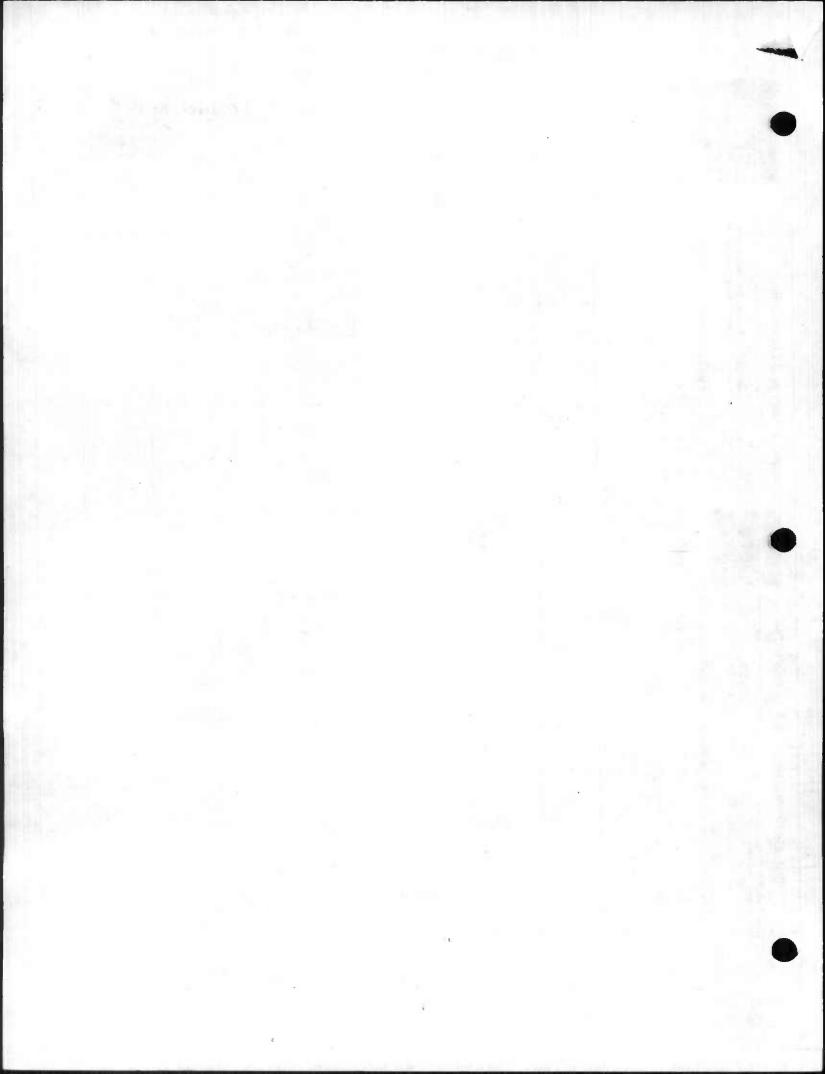
State of Maryland / Department of Health and Mental Hygiene Q Q

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	/Medic		Mabel C.	Itolmes					12	- 11	99	0910
À.	Examir	er	4e. Fecility Neme (If not institution, given	'e street end number)				4b. City, Town, or				
			5. Sociel Security Number 6. S	2.4	the come to a his	at to a Hillor	der 1 Year	Williams If Under 24 Hrs			Lings	
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	land w		10a. Stata 10b. County	1	Oc. City, Tow	n or Location				·	10	Od. Insida City Limits
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	h with the 23a or 284	al Director	10e. Street and Number 16505 Virginia A	venue		10f. 2	Zip Coda	21795		10g. Citizen of V	A .	ry?
020	be filed within 72 hours after deeth with the Maryland tiel Hygiene. d other than "natural", or items 23a or 28a-f ahow avent, the Medical Examiner must be notified at	by Funeral	11. Maritel Stetus 1 □ Navar Marriad 2 □ Married 3 ☼ Widowed 4 □ Divorced	12. Was Decedant Ev Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas:	er in U,S.		cedent of F pecify Cub 2 No	dispanic Origin? (S en, Maxicen, Puar Specify:	Specify Yes or No to Ricen, atc.)	14. Race Blac Specify	e - America k, Whita, a . whi	atc.
Maryland 21215-0020	vithin 72 hone.	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 0-12	ducation ada complatad) Collega (1-4or 5+)	16a.			oation during most of wo d)	rking	16b. Kind of Bu		
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Baltimore,	permit. Peges 1 and 3 Department of Heelth Important: if Itam 27 I any Injury or other tri		20a. Mathod of Disposition 1 ⊠Burial 2 □ Cramation 3 □	Removel from State	20b. Place 0	f Disposition (A	Vama of		Data	20c. Location -	City or Tox	wn, Stata
Ē	ortani Injury		4 ☐ Donation 5 ☐ Other (Specification of Funeral Survice Licenses)		Hedro			ess of Fecility		Funeral		Maryland
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			30. Nama and addrass of person who		th (itam 23a)	(Type, Print)		-/			/	
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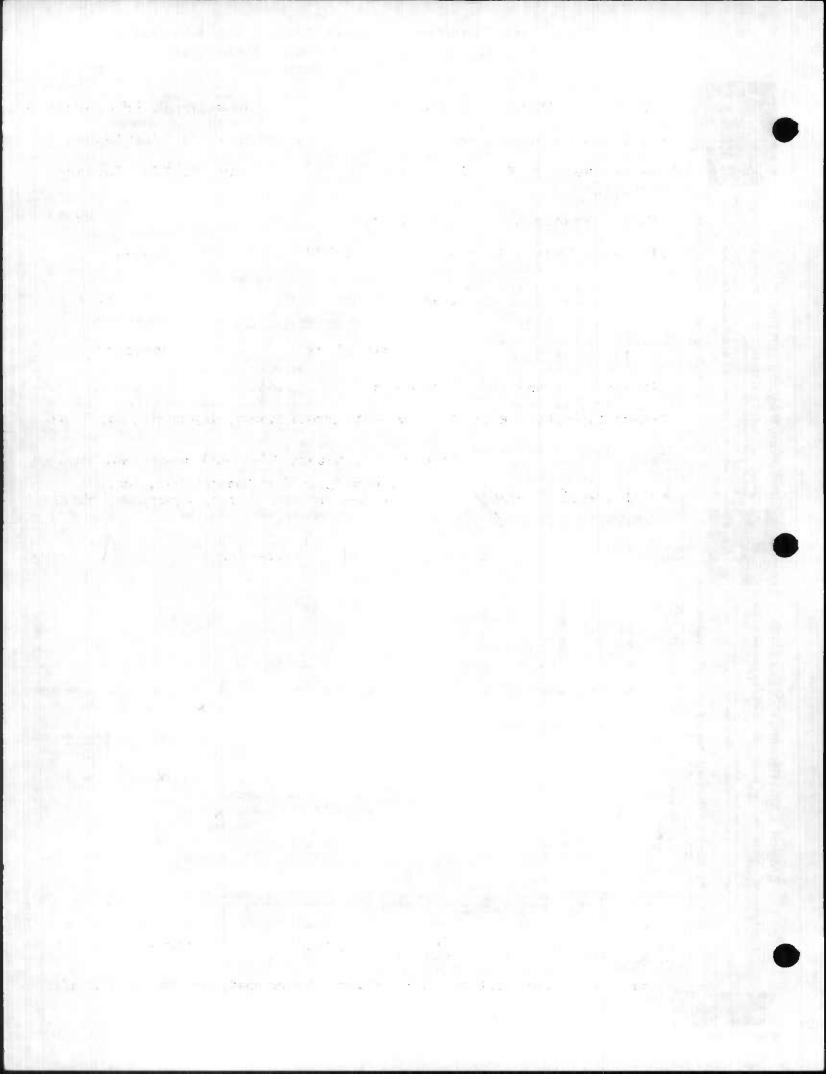
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended State of Maryland / Department of Health and Mental Hygiene Line 7. SC Certificate of Death 12-14-99 WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** December 10 1999 **BROOKS** /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON Hours Min. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1⊠M 2□ F 88 89 Yrs. 232-26-7567 Director 1909 WEST VIRGINIA Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No 28a-f Directo MARYLAND WASHINGTON KEEDYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ne 23e or 3643 CHESTNUT GROVE ROAD 21756 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Biack, Whita, atc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 Pages 1 and 2 should be filed within 72 hours aft ment of Heath and Menta! Hygiene. sust if flem 27 is marked other than "natural", or usy or other traumatic event, the Medical Examin. 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AEROSPACE CONTRACTOR STOCK CLERK Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOHN MORRA HINES EMMA FRANCES HERMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) THELMA M. HINES/SPOUSE 3643 CHESTNUT GROVE ROAD, KEEDYSVILLE, MD 21756 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or any injury or any ence. 4 ☐ Donation 5 ☐ Other (Specify) 12/14/99 SHARPSBURG, MARYLAND SAMPLES MANOR CEMETERY 21. Signature of Funeral Service Coenses 22. Name and Address of Facility 7606 Old NationalPike Paul M. Dean BAST FUNERAL HOME Boonsboro, Maryland 21713 23a. PartT. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death Physician fmmediate Cause (Final diseasa or condition resulting in death) /Medical Examiner Physician/Medicai Examiner hysician and the burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ATHROSCLEROSIS Due to (or as a consequence of): US0 88 Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 48 Unknown ONGESTIVE HEART þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 □ Yas 2 □ No 25. Was casa referred to medical examiner? 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) edical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Naturat 2 Accident 5 Pending investigation death. 1 Yes 2 No s after death 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DECEMBER 11, 1999 D44996 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) MD 21713 BOONSBORD MALIK 20311 LAPPANS 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State DEC 1 4 1999 Registrar

DHMH 16 Rev 6/95



			State of Maryland / Department of Health and M Certificate of Death	епа пу	Reg. No.	Le	1565
	Physicia: /Medica	n	DOREEN AUDREY HOLLAR	2. Dete of Do Month Decemb	Dey	reer 199	3. Time of Death 10:00 AM
	Examine		e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Lo	cation of Deal			
	Funeral Director	5	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	8. Dete of Bi		9. Birthpl Coun	aton lace (State or Foreign land
	pu ,	-	Jsuel Residence of Decedent 0a. Stete 10b. County 10c. City, Town or Location			1/	0d. fnside City Limits
	show						1 Ves 2 No
	28a-1	8 -	Maryland Washington Hagerstown Oe. Street and Number 101. Zip Code		10g. Citizen of Wh	et Coun	to?
	3a or	5	343 South Cannon Avenue 21740		U.S.		
21215-0020	should be filed within 72 hours efter death with the Maryland Mahould be filed within 72 hours efter death with the Maryland Mahould Hygiene. Teached other than "retural", or items 23e or 28e-f show marked other than "retural", or items 25e or 28e-f show marked other than "return". To Be Completed by Funeral Director	2	1. Manitel Status 1. Manitel Status 1. Manitel Status 1. Was Decedent Ever in U,S. Armed Forces? 1. Never Married 2. Married 3. Widowed 4. □ Divorced 1. Was Decedent Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces? 1. Was Decedent Ever in U,S. Armed Forces? 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces?) 1. Was Decedent of Hispenic Origin? (Sperify Ever in U,S. Armed Forces?)	ocify Yes or No Rican, etc.)	14. Rece Bleck, Specify:	White,	efc.
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more,	of Heelth Kem 27 other tr	2	Oe. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetery or other plece)	Dete	20c. Location - C	ity or To	wn, Stete
E	Pages nent of I		X Buriel 2 Cremetion 3 Removel from State Rose Hill Cemetery 12	13-99	Hagersto	wn,	Maryland
Balt	permit. Pages 1 an Department of Heel Important: If Item 2 any Injury or other ance.	2	21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Andrew K. Colliman	-uneral	L Home, I	nc.	Md 01740
			23a. Pert1. Enter the disease, or complications with lused the deeth. Do not enter the mode of dying, such as cardiec of shock, or heart failure. List only one cause with line.			√∩,	Md. 21740 Approximete
	Physician /Medical	1	mmediate Ceuse (Final disease or condition			4	Intervel Between Onset end Deeth
	Examiner		esulting in death) Due to (or es e consequence of):				
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68760,	icate be axecuted physicien and s the buriel-transit	65	Sequentially list conditions, feny, leeding to immediate ause. Enter Underlying Cause (Disease or Injury het initiated events C				
Box 687	attending phy		Due to (or es e consequenca of): d				
	daath d for	5 F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did	I tobacco use cont	ribute to	the cause of death?
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Records,	requi	Completed b			s en eutopsy ormed?	8V8	ere eutopsy findings alleble prior to mpletion of cause death?
	ysician: The law ils certificata hes t director, page 2 s	E		10	Yes 2 No	10	Yes 2□ No
ita Ita	stan: ertifica		25. Wes case referred to medical exeminer?	(Check only	one)		
5	Physician: r this certific and director,	<u> </u>	1 ☐ Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hot	-	idence 6 Other		0
UQ.	of et a		1 Neturel 5 Pending (Month, Dey Year) Injury Work?	28d. Describe	how Injury occurre	d	
Division of Vital	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completaly filled in by the funeral di	Cerification:	2 Accident	28f. Location City or To	(Street end Number own, Stete)	r or Rura	I Route Number,
	To the Hospital within 24 hours a within 24 hours a To the Funeral I completaly filled		29e. Certifier (Check only one) Medicat Examine: To the best of my knowledge, deeth occurred et the time, dete end pleca, and the place of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and the place of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and the place of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and the place of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and the place of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end pleca, and the place of examinetion end/or investigation.				
	o the	main .	19b. Signe ire end title of cartifier 29c. License number		29d. Date signed	(Month,	Dey, Year)
	F S F 0		D23623	-	December	10	, 1999
		3	Name and eddress of person who completed cause of death (Item 23a) (Type, Print)				
			Frederic H. Kass III MD 11110 Medical Campus Ro	ad. Ha	gerstown	Md	. 21742
	State Registra	-	DEC 1 3 1999 32. Registrar's Signature 4. Abanda				

Registrar DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Yes Lizzie Horst December 10, 1999 3:15 P.M. 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Mennonite Old People's Home Hagerstown Washington If Under 1 Yeer If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 M 20 F Yrs 219-36-2535 87 July 3, 1912 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Md. Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13436 Maugansville Rd. 21740 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, epecify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 KNo Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Housework 8 Individual's Homes 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Martin L. Horst Mary Baer 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ammon H. Martin/Nephew 19765 Leitersburg Pike Hagerstown, Md. 21742 20b. Placa of Disposition (Name of cemetery, crematory or other plece) Reiff 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mennonite Church Cemetery 12/14/99 Cearfoss, md. 21. Signature of Funerel Servica Licenses 22. Neme end Address of Facility Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 17225 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediete Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uss contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Tyes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 28. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2M No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Director

Funerai

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Funeral

Director

Hem 27 is marked other than "natural", or hems 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or flems 23a any Injury or other traumatic event, the Medical Experimental pages.

Baltimore, Maryland 21215-0020

with the Maryland

Examiner Physician/Medicai þ Completed 8 2 Certification:

ng physiclan and as the burial-transit

that the death certificate be axecuted Division of Vital Records, P.O. Box 68760, signed by the attending I be detached for use as peen has certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica funeral director, completely filled in by the To the Hospital within 24 hours a To the Funeral D

> State Registrar

Medical

6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, offica bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔏 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Madical Examinar: On the besis of examination and/or investigetion, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

1 Yes 2 No

(Check on! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

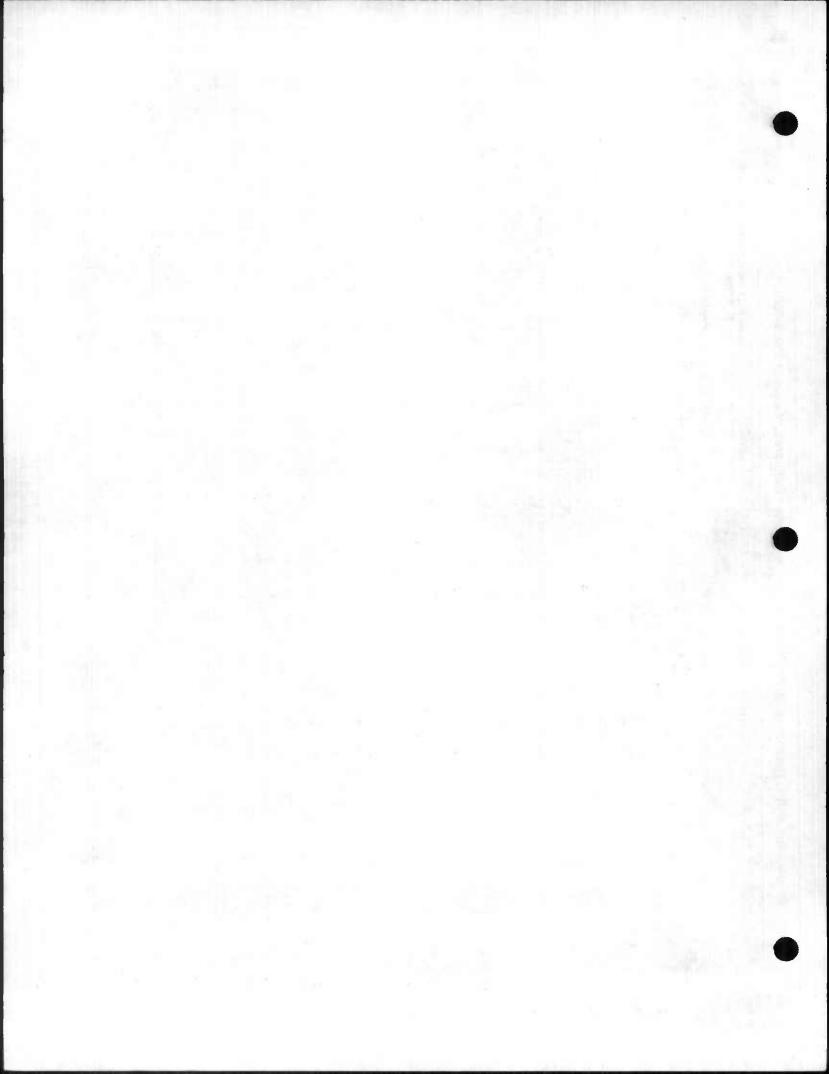
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Central Rd / legers town

coleric 2100 ma 131 31. Date filed (Month, Day, Year)
DEC 1 3 32. Registrar's Signature

11110

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician **JAMES** HURD DECEMBER 9 1999 **EDGAR** 5:36 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 2, 1928 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days 1MM 20F 71 Yrs. 219-20-4613 Director Usual Residence of Deceden the Maryland 10a State 10h County 10c City Town or Location 10d. Inside City Limits tem 27 is marked other than "natural", or flams 23s or 28s-1 show other traumstic event, the Mexical Exemples must be notified at Maryland Frederick Frederick ₩Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5736 Butterfly Lane 21703 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: white Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Heelth and Mental Hyglena. Important: If Item 27 is marked other than "nationy injury or other traumatic avent, the Medical DACE. commercial & residential Elementary/Secondary (0-12) College (1-4or 5+) painting & construction contractor 0 - 9contruction 18 Mother's Name /First Middle Maiden Sumemel 17. Father's Neme (First, Middle, Last) 8 Roy E. Hurd unknown Ada Gorman 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Alice M. Hurd / wife 5735 Butterfly Lane, Frederick, Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Dec. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 13,1999 Hagerstown, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. eg. signed by t 1 Yes 2 10 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of deeth? 1 Yes 2€ No t Yes 2 No Division of Vital al or Attending Physician: T s efter death. Il Director: After this certificat ed in by the funeral director, pu 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 2 No 2 Accident n 24 hours efter de ne Funeral Directo pletely filled in by the 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours of To the Funeral D Medical 29a. Certifier t Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and life of 29c. License number 29d. Date signed (Month, Dey, Year) e of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Mon State DEC 13 Registrar



Please Type or Print in Biack indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day 1999 **Physician** December -Lovetta Lorraine Hook 6:30 A.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11442 Rock Hill Rd. Wasgington Hagerstown If Under 24 Hrs. Hours | Min. 8. Date of Birth (Month, Day, Year) 27 5. Social Security Number If Under 1 Yaar 7. Age (In vrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** Days Months 1□M 2☑F Maryland 219-20-1452 71 Director Usual Residence of Decedent death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f ahow 1 ☐ Yas X ☐ No Director Md. Washington Hagerstown 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 permit. Pages 1 and 2 should be filled within 72 hours after death w Department of Health and Mental Hygiens. Important: If item 27 is marked other than "instureit, or herms 23a is any injury or other traumatic event, the 11442 Rock Hill Rd. 21740 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11 Marital Status Biack, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 10 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) 8 Earl James Hann Irene Ida Zentmuer 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Carl B. Hook Jr. (Husband) 11442 Rock Hill Rd. Hagerstown, Md. 21740 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Dortal 2 Ocremation 3 Removal 5 Other (Specify) Smithsburg Crematory Dec. 10, 1999 Smithsburg, Md. Donatio 22. Name and Address of Facility Signature of welce I icon Pavis Funeral Home 12525 Bradbury Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, A shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** /Medical Immediata Causa (Finai ourcinem diseasa or condition resulting in death) Examine Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sens Physician/Medical o (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by to 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to complation of causa of death? Completed 24a. Was an autopsy performed? Deen page 2 s 2 X No 1 ☐ Yas 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director; Affer this carlifical completely filled in by the funeral director, I 25. Was case refarred to medical axaminer? 8 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Matural 2 Accident 5 Pending investigation 1 Yas 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

The law requires that the death certificate be executed Box 68760, Division of Vital Records, P.O.

Baltlmore, Maryland 21215-0020

State Registrar

DHMH 16 Rev 6/95

31. Data filed (Month, Day, 1) Year)

29b. Signatura and titla of certifie

30. Nama and addrass of pe

(Check only one)

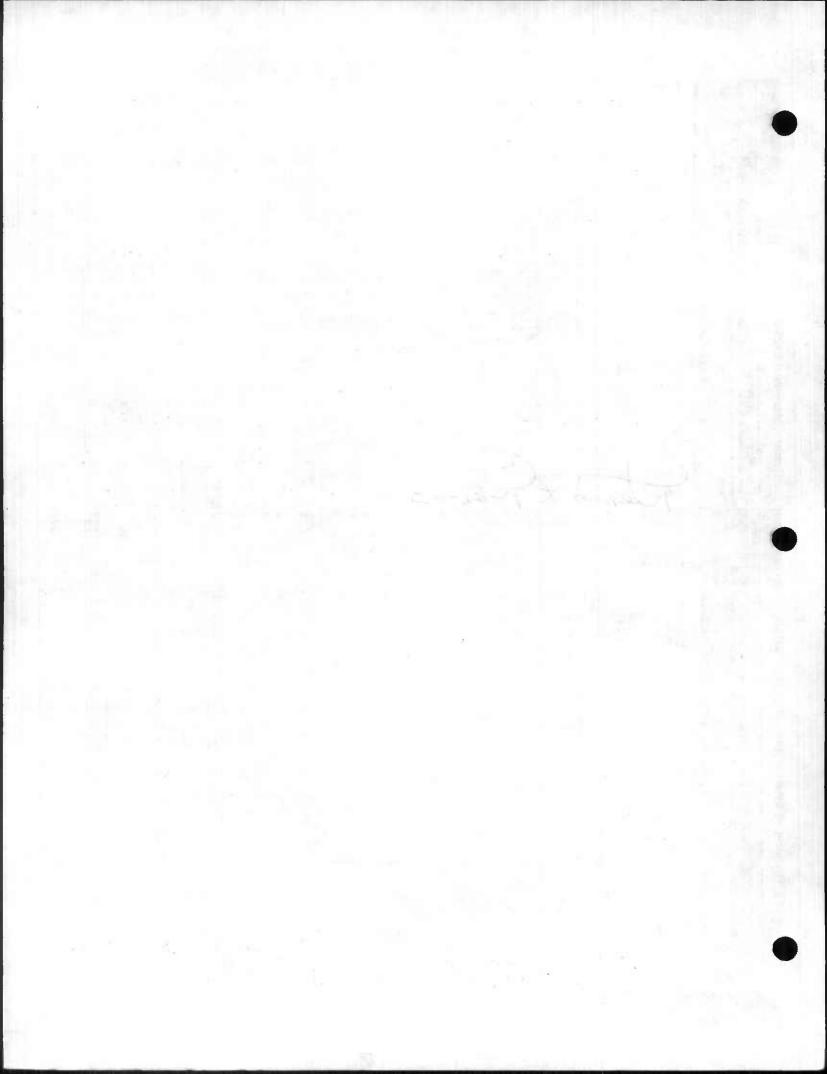
(Item 23a) (Type, Print) 32. Elegistrar's Signature

29c. Licensa number

29d. Data signed (Month, Day, Year)

Williamspor

ecember 10, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Dev Yee **Physician** William Joseph Hodges 14 1999 6:00 PM December /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health of Forest Hill Forest Hill Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplace (State or Foraign Country) **Funeral** Deys Months Hours 1**⊠**M 2□F Yrs. 218-22-1862 74 Director 10, 1925 Maryland Usual Rasidence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits the Marylar 25a-f show must be notified at 1 TYas 2 TXNo Director Maryland Harford Forest Hill 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? therns 23a or Apt. 2B 21050 USA 1704 Richway Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ⊠ Yas 2 □ No If Yas, Give Yaer or Dates: Korea 13. Wes Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indien, 11. Meritel Stetus Black, Whita, etc. 72 hours after 1 Navar Marriad 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 ☐ Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced White Korea Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry permit. Pages 1 and 2 should be filled within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n Aeronautical Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Electrician Manufacturing 17. Fethar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Dorothea (u/k) Herr Victor William Hodges 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 1704 Richway Apt. 2B , Forest Hill, MD 21050 Hazel B. Hodges / Mother 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 MCremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 12-17-99Towson, Maryland Hilltop Service Corp. 21. Sign 22. Name and Addrass of Facility itum of Funeral Service Licenses McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head fullura. List only one ceuse on each line. Approximata Intarval Batween Onset and Death **Physician** Immediate Ceusa (Finel disease or condition rasulting In death) /Medical L2 money Examiner Due to (or es e consequence of) Examiner physician and s the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, laeding to immadieta causa. Enter Underlying Cause (Disease or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Due to (or es e consequance of): 88 080 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. Division of Vital Records, P.O. 94 signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? Completed Deen The law hes page 2 certificate 1 ☐ Yas 2 ☐ No 1 □ Yas 2 □ No Physician: director. 25. Was casa rafarred to medical axaminar? 8 26. Place of Death (Check only one) 0 1 ☐ Yas 2 No Hospital: Other: Nursing Homa 5 Residence 6 Other (Specify) 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral 27. Mannar of Death 28s. Dete of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Netural 5 Pending investigation or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fu 1 TYas 2 TNo 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 6 ☐ Could not be 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 ☐ Homicida vithin 24 hours of the Fire Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar es stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29e. Cartifiar Medical (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura end titla of certifiar

State Registrar

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31. Data filed (Month.

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30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print)

1999^{32. Registrar's Signatura}

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State of Maryland / Department of Health and Mental Hygiene

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Į,	Physici /Media Examir	cal	Hilda Kathryn Joh		Hilda	Kathryn		son GUTH	Dec.	14 199	9	6:50	a.m.
	Exami	iei	Homewood Nursing					William	nenort		shing	ton	
	Funeral		5. Social Sacurity Number 6. Se	7. Age	e (in yrs. iast		dar 1 Yaar	If Undar 24 Hrs.				laca (State o	or Foreign
	Director		220-44-7986 Usual Residence of Decedent	□М 2Д F	87	Yrs. Month	is Days	Hours Min.	Feb. 1	3 1912	Mary	land	
	how		10a. State 10b. County		10c. City, To	own or Location					1	0d. inslde C	
	Sa-f	Director	Maryland Washing	gton		Hage		n					2 No
	or 2	Dire	10e. Street and Number			10f. 7	Zip Code			10g. Citizan of V		try?	
	23a	rai	107 Linden Avenue		1.110	10.111 - 0		1740		U.S.A			
050	s 1 and 2 should be filed within 72 hours after deeth with the Meryland of Heeth and Mental hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examinet must be nothing at	by Funeral	11. Marital Status 1 ☼ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedant II Armed Forcas? 1 Yes 2 N If Yas, Give Year or Dates:			pecify Cub	Hispanic Origin? (S ean, Maxican, Puart Specify:	pecity Yes or No- o Rican, atc.)	Specify			
9-0	2 hou	8	15. Decedent's Ed	ucation	10	6a. Decedent's U	sual Occup	pation		16b. Kind of Bu			
21215-0020	bin 7	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5	(+)	(Giva kind of life. DO NOT	work dona use retire	during most of world)	rking				
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Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			Haven Co			12/16/99	Hagers	e t out	Mar	wland
alti	나는 전 등		21. Signature of Funeral Sarvica Licans		Rest				Minnich				yland
Ö	Depermine Deperm		Sentin	Mini	4	415 1	E. Wi	lson Blv					
			23a. Fait1. Enter the disease, or companies, or heart failure. List only	olications that caused	the death. D	Oo not enter the m	ode of dyi	ing, such as cardia	or respiratory ar	rest,	- 1	Approximat Interval Bet	te
	Physician /Medical		immediate Cause (Finel	Ma	(1060)	64		diov	0.6	Porce	20	Onset and	
	Examiner	l,	disease or condition resulting in death)	e. / Y 34	Due to (or as	a consequence		aww	IN Cofa	Cene	He	76	_
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		Physician/Medical	resulting in death) Last		Due to (or as	a consequence o	n).						
Box		an/N		d							1		
	the att	sici	Part ii. Other significant conditions co	ntributing to death bu	ıt not resultin	g in the underlyin	g cause gi	ven in Part i.	23b. Dld t	obacco use cor	tribute to	the cause	of death?
P.0	that the de ed by the deteched		Alos / Fly/	Son					103	Yes 25 No	3 Prot	oably 4) Unknown
Records,	requires been sign should be	Completed by	7 10007 65 75110							an autopsy rmed?	ava	are autopsy allabie prior mpletion of death?	to
R	The lew sate hes page 2:	mo:							101	res 2 No	10	Yes 2] No
Vital		Be C	25. Was case referred to medical examiner?					28. Placa of Dea	ath (Check only o	ne)			
of V	Q 66 X	To	1 ☐ Yes 2 No	Hospital: 1 inpatle	nt 2 ER/	Outpatient 3□	DOA Ot	her: Nursing H	lome 5 ☐ Resid	dence 6 Othe	er (Specify	1)	
n	The first		27. Manner of Death 1 Neturei 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 281	b. Time of injury	28c. inju Wo	ork?	28d. Dascribe h	now injury occurr	ed		
Division	or Attendifier dest Mrector: In by the	Certification:	2 Accident Investigation 3 Sulcida 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At home : (Specify)	M , farm, street, fact]Yes 2□No	28f. Location (S City or Tox	Street and Numb vn, State)	er or Rura	l Route Nun	nber,
_	To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one) 1 Certifying Phy	raician: To the best of iner: On the basis of and manner ste	of my knowled examinetion	dge, deeth occurre and/or investigati	ed at the ti	ime, date and place opinion, death occu	, and due to the ourred et the time,	cause(s) end ma dete end plece, a	nner as at and due to	ated. the ceuse(s)
	ompie	Me	29b. Signature and title of certified	A Sie			29c. Licen	se number		29d. Dete signed	(Month,	Day, Year)	
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			30. Name and address of person who d	ompleted cause of de	eath (item 23	a) (Type, Print)	0		10	16/1	4/1	_	
			AMD; Kow	747	NO	Hor	M	e IXC	9000	mu V	W	217	112
	Sta	ite	31/Date filed (Month, Day, Year)	32. Registra	ar's Signatura	4	lan		1				



				Certifica	te of	Death		Reg. No.	./		
Physician	Decedent's Nama (First, Middla, La Andrew Johnson JO						2. Date of De Month	Day.	Year	Time of Death	
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Examiner	Washington County						erstown		shingto	n	
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a notified at Director	Maryland Washin	cton	loo. ony, ron		or m					1 ☐ Yes 21 No	
Directo	10e. Street and Number	gcon		Hagerst	ip Code			10g. Citizen of V	What Country?		
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Funeral	11. Marital Status	12. Was Dacedant Armed Forcas?	Evar In U,S.	13. Was Dec	edent of H	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No	- 14. Rac	e - American I ck, Whita, etc.	ndian,	
à	1 ☐ Nevar Married 2☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yas 2 ☐ If Yas, Giva Yaar or Datas:		1 ☐ Yas		Specify:	10 10001, 010.7	Specify	The state of the s	nite	
pote	15. Decedent's E (Specify only highast gra	ducation	16a	Decedent's Us	ual Occup	eation during most of wo	rkina	16b. Kind of Br	usiness/Indust	y	
Completed	Elementary/Secondary (0-12)	College (1-4or		lifa. DO NOT	use retired	d)			1 1		
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o Be	Lewis R. Jones					th Dusan		ia)			
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	Josephine E. Jon	es - wife		425 Ch	artr:	idge Dr.	, Hagers	town, Mo	1. 2174	2	
Important: If any injury or ansa.	1 M Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Othar (Specify) 21. Signatura of Funaral Service Licensee 22. Nama and Addrass of Facility MINNICH FUNERAL HOM 415 E. Wilson Blvd., Hagerstown, Md										
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within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	4 Homicida datarmined 29a. Cartifiar 1 Certifying Ph	building, at nysician: To tha best of niner: On tha basis of and manner sta	c. (Specify) of my knowledge	a, death occurre	d at the tir	ma, data and place	City or Too	wn, State) cause(s) and ma	anner as state	d.	

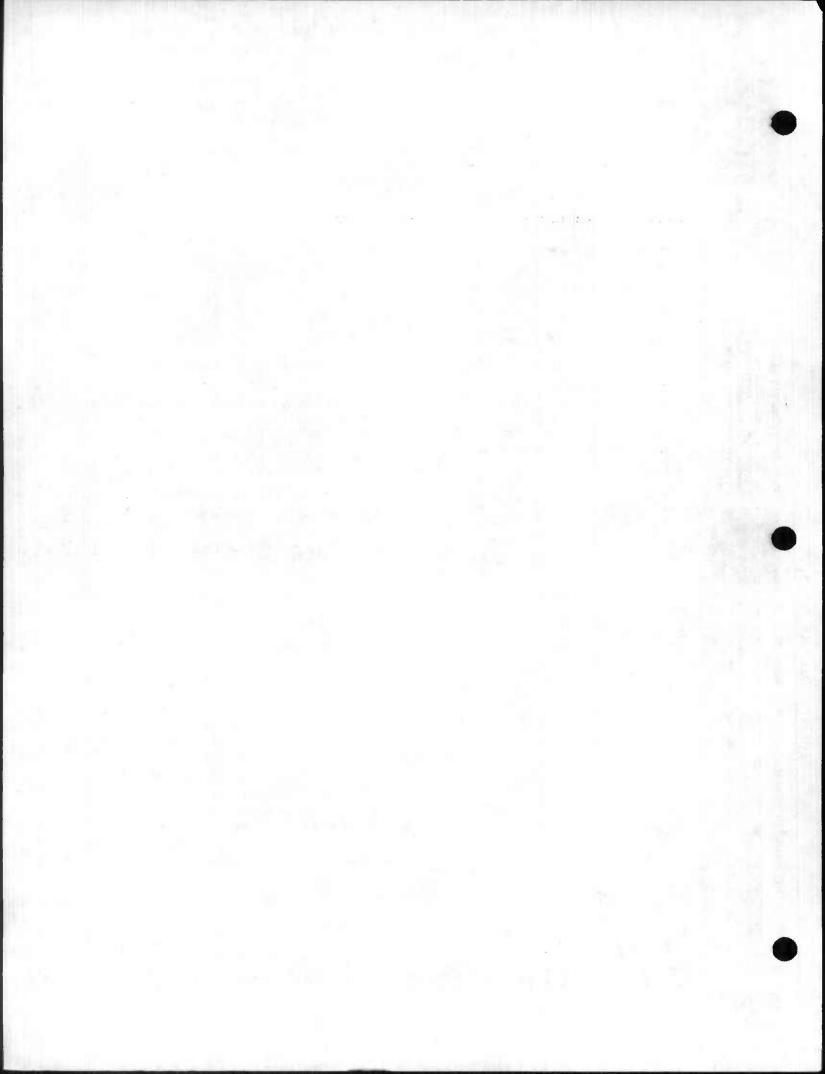
State Registrar

31. Data filed (Month, Day, Year)
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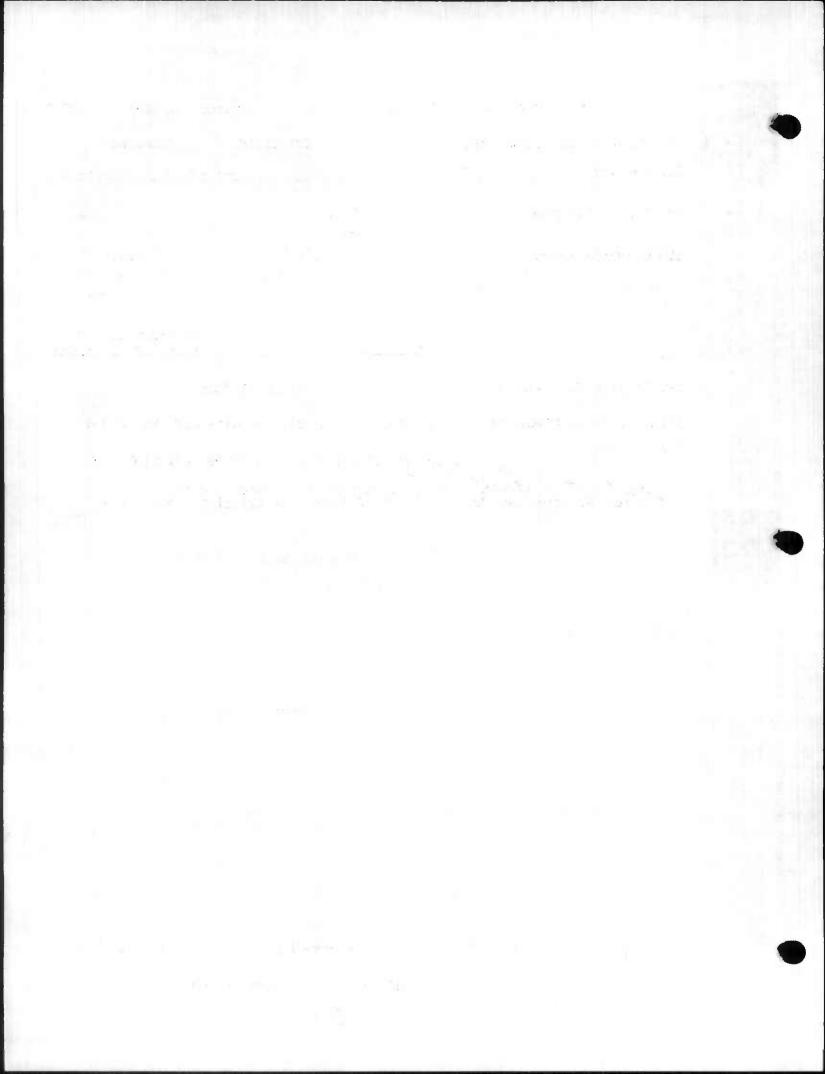
causa ot daath (Item 23a) (Type, Print)

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene

170				Ce	ertificate of	Death		Reg. No.	0 1.	1570
Physic	ion	1. Decedent's Name (First, Middle, La	ist)				2. Date of De	eath bay	Year	3. Time of Death
/Medi		DOR	OTHY S.	KELLA	AM .		December		99	6:05 P.M.
Exami	ner	4e. Fecility Name (If not institution, given					Location of Deat	h 4c. County	of Death	
		McCready Memori			WILL 1 4 M	Crisfi		Some		
Funeral Director		215–38–0116	Sex 7. Age (In 1	yrs. last birthdey Yrs.	Months Days		. (Month, De	th ay, Year) 9, 1912	Coun	lace (State or Foreign try) Yland
Pu &		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or L	ocation				Τ.	Od Jasida Oikak India
r 28a-f show	Director	Maryland Somer	. 1		Crisfield	d 				0d. Inside City Limits 1 Yes 2 No
th with the 23a or 2		10e. Street and Number 103 Columbia Ave	nue		10f. Zip Code	21817		10g. Citizen of V	What Coun	try?
d 21215-0020 filed within 72 hours after death with the Maryland Hygiena. ther than "natural", or flame 23a or 28a-1 show ont, the Medical Examinat must be inclined at	by Funeral	11. Maritel Status 1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates:	in U,S. 13.	Was Decedent of If Yes, specify Cul 1 ☐ Yes 2 XNo	Hispanic Origin? (ban, Mexicen, Pue Specify:	Specify Yes or No rto Ricen, etc.)		e - America k, White, o : White	etc.
215-002 thin 72 hours an "natural;	Completed	15. Decedent's E (Specify only highest gre		(Give	edent's Usuel Occu	e during most of wa	orkina	16b. Kind of Bu		
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Mar 12 sh and 1s m		19a. Informant's Name/Relationship (et and Number or F				
		Alice K. Ayers (Lost Fav osition (Name of	wn Drive			-	
Baltimore, semit. Pages 1 er separtment of Haa mportant: If Itam 2 iny Injury or other MCE.		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, cre	e Memorial		Date 12/21/99	20c. Location - Crisfi		
Baltimo permit. Pages Department of Important: If it any injury or other.		21. Signature of the analysis of Lorentz March 1989	I Blake	1	2. Name end Addr Bradshaw	& Sons F	uneral H	Iome		
		Robert H. Br 23a Part 1. Enter the disease, or com	plicetions thet caused the			ain St			21817	Approximate
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/Medical	Ш	Immediate Cause (Final		A	. 14	- 1.	, tu	1- (-)		
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of Vital I Physician: The this certificate ral director, pag	Be (25. Wes case referred to medicel examiner?				26. Place of De	eath (Check only	one)		
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Jing After fune		27. Manner of Deeth 1.20 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	W	ury at ork? ☐ Yes 2 ☐ No	28d. Describe	how injury occur	red	
Division of a transfer of a tr	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, st	reet, lactory, office)	28f. Location (City or To	Street and Numb wn, State)	er or Rura	Route Number,
Divisit To the Hospital or Attand within 24 hours eiter deat To the Funeral Director: completaly filled in by the	edical C	29a. Certifier (Check only one) 1 Cartifying Ph	ysician: To the best of my niner: On the basis of exen and manner stated.	knowledge, deat nination and/or Ir	th occurred et the to exestigation, in my	time, date and plac opinion, deeth occ	e, and due to the surred et the time,	ceuse(s) and ma date and place,	inner as st and due to	ated. the cause(s)
To the Within To the	ĕ ≅	29b. Signature and title of certilier	and mained stated.		29c. Licen	nse number	Т	29d. Date signer	d (Month. I	Day, Year)
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		20 Name and 1	V J			10018		12	20	7 4
		30. Name and address of person who					elas s	m 0101	7	
0.		Vijay Karumbuna 31. Date filed (Month, Day, Year) DEC 2	32 Renistrariors	ZUI Hal	rt Highwa	y - Cris	rield, M	1D 2181	1	
Sta Registr	rar	DEC 2 3	than, M.D. –	neva	B. A.	Darks!				



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No: 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Gertraud Mare Kennedy Dec 1999 2015 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western Maryland Hospital Center Hagerstown Washington If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiece (State or Foreign Country) **Funeral** 1□M 2XF Months 022-30-4338 74 Yrs. Director Mar 29, 1925 Cosel, Usual Residence of Decedent the Meryland parmit. Fages 1 and 2 should be titled within 72 hours efter death with the Merylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumable event, the Medical Examination must be multiped at 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits Md Washington 1 ☐ Yes 20No Director Cascade 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21719 25326 Sprindale Ave USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ॲ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Tyes 2 No Specify: Specify: White þ 3 □ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementery/Secondery (0-12) Book Publisher 12 Inspector 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Otto C. Berghof Marie Rominchek 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Edward R. Kennedy, Sr 25326 Springdale Ave Cascade Husb 20e. Method of Disposition

1 Buriel 2 Deremetion 3 Removel from State
4 Donetion 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 12-22 Waynesboro PA 17268 Cumberland Valley Crematorium 21 Signature of Funeral Service License 22. Name end Address of Fecility Grove Funeral Home, Inc. 50 S Broad St Waynesboro PA 17268 ames Sowerso Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, if heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** aleuli /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner sician and burial-trens Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) physician a the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of). 98 USB Pert II. Other significant conditions contributing to death but not resulting lighe underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? signed by t d be detect 1 Yes XX No 3 Probably 4 Unknown à 24b. Were eutopsy findings eveilable prior to Completed 24a. Wes en eutopsy completion of cause of deeth? hes 1 ☐ Yes 2 ☐ FIII 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medicel examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XNo Certification: To 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a, Date of Injury (Month, Dey Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Waturel 5 Pending investigation 24 hours after death. Funeral Director: Af 1 Yes 2 No 2 Accident within 24 hours after dea To the Funeral Director completely filled in by th 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end menner stated. 29a. Certifier edical To the 29d. Date signed (Month, Day, Year) 29b. Signalare end title of certifier 29c. License number D36655 December 18, 1999

State Registrar 30. Name end address of person who completed ceuse of deeth (Item 23a) (Type, Print)

1185 Mt Aetna RD

32. Registrer's Signeture

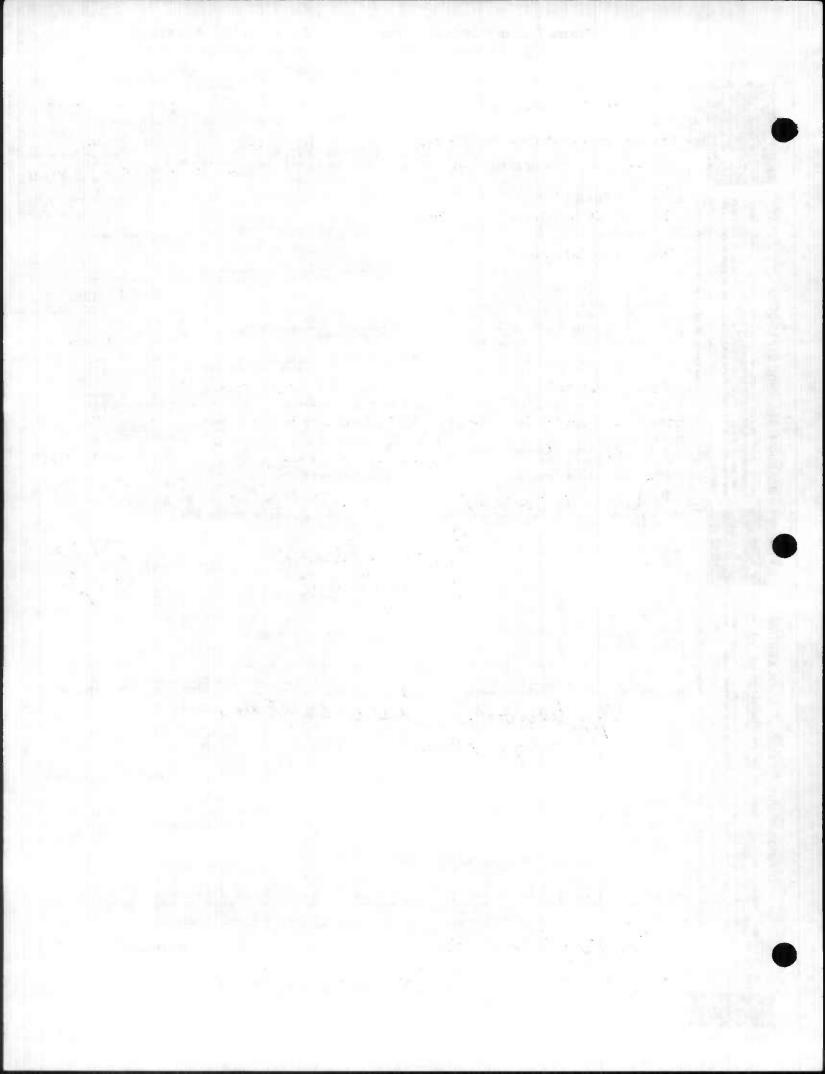
21740

MD

Hagerstown

Samuel Chan, MD

31. Dete filed (Month, Day, Yeer) DEC 21 1999

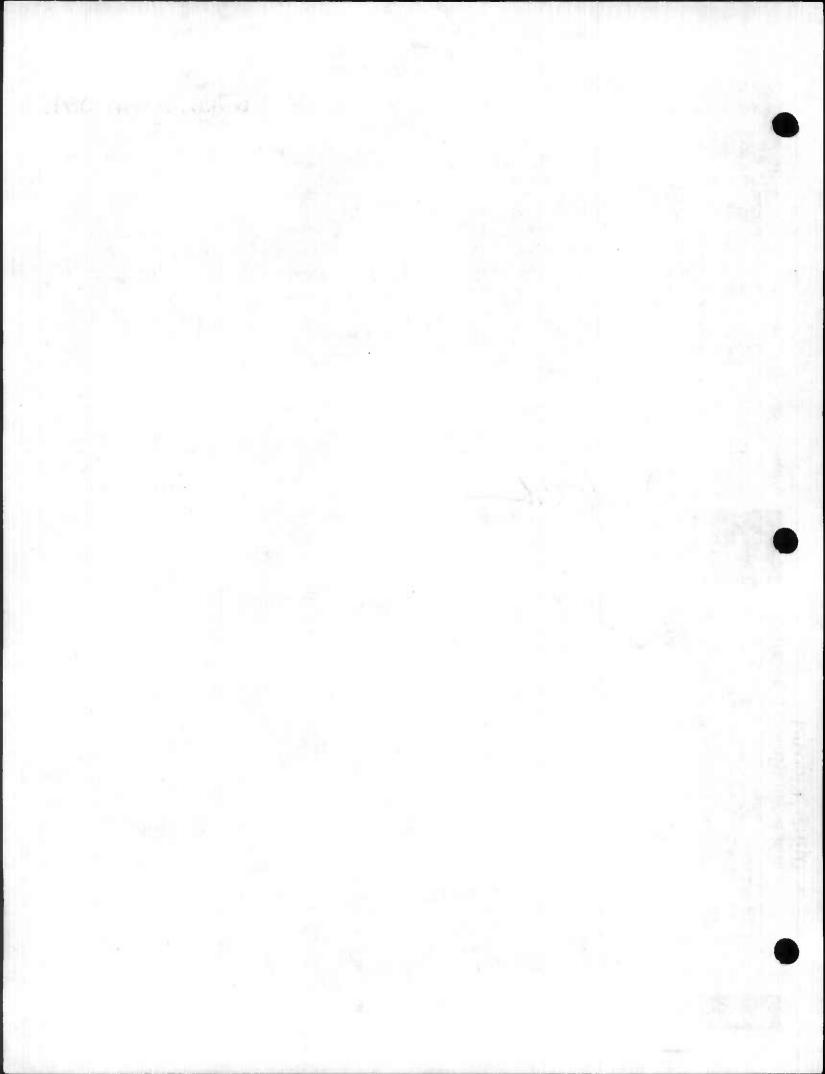


		State of Man		epartment of Certificate o			eg. No.	39	41574	
Physician /Medical			ls			2. Date of Dear Month December	th Day	Year	3. Time of Death	
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Funeral Director	214-36-1503		n yrs. last birtho	Months Day			Year) 1940	9. Birthpl Count M	lace (State or Foreign try) D	
the Maryland 28s-1 show notified at	Usual Residence of Decedent 10a. Stete 10b. County MD Washir		Clea	r Location r Spring	,			10	0d. Inside City Limits 1 XYes 2 □ No	
6 0 W	10e. Street and Number 11 Cumberland	st.		10f. Zip Code 217		1	0g. Citizen of U.S.			
ours after death voirs after death voir stems 23e Examiner must. By Funeral	3 ☐ Widowed 4 ☑ Divorced	12. Wes Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Dates:	or in U,S.	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2X N		Specify Yes or No- to Rican, etc.)	No- 14. Race - American Indian, Black, White, etc. Specify: White			
Maryland 21215-0020 d 2 about be filed within 72 hours at the and Marial Hygiere. The marked other than "natural", or traumatic event, the Medical Exami	(Specify only highest g Elementery/Secondery (0-12) 9th grade	Education rade completed) College (1-4or 5+)	16a. D.	ecedent's Usuel Occ ive kind of work don te. DO NOT use reti Constru	ction		Construction Co.			
ahould be file and Mental Hy americal othe americal othe To Be C	17. Father's Neme (First, Middle, Las	*				me (First, Middle, I Lotte F	Maiden Sumar Repp	ne)		
tealth and h	19a. Informant's Neme/Reletionship Sondra Johnso	11	nb. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1 Cumberland St. PO Box 134 Clear Spring, I							
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Depart Depart Import any in anse	21 Signature of Funeral Service Lips	111		Donald PO BOX	Edwin Th	nompson ar Sprin	Funer	al H	ome, Inc	
Physician /Medical Examiner	23a. Par 1. Enter the disease, or conshick, or heer failure. List only Immediate Ceuse (Finel disease or condition resulting in death)	· Exacertek	d Christe con	nsequence of):			rox		Approximate Interval Between Onset and Death 4 day 4 day	
ding physician and sa as the burish-transit	Cause (Disease or injury thet initiated events resulting in deeth) Last	c. preu	e to (or as a con						(4) deg.	
v requires that the death certific been signed by the attending pshould be detached for use as should by Physician/Me	Part II. Other eignificant conditions	contributing to death but no	ot resulting in th	e underlying cause (given in Pert I.	23b. Did to			the cause of death?	
> 100 =					22 -	24a. Wes e perfori	med?	ava con of c	ore eutopsy findings hilable prior to appletion of cause death?	
Physician: The law requires the thick certificate has been signed in director, page 2 should be called by the Completed by the called by the c	25. Wes case referred to medical axeminer?	Hospitel:	-5		Where	eth (Check only on	ne)		Yes 2 No	
After fune	27. Manner of Deeth 1 Neturel 5 Pending 2 Accident investigation 3 Suicide 6 Could not	28a. Dete of injury (Month, Day Ye	- At home, farm	e of y M 1	ury st ork? Yes 2 No		ow injury occur	red	I Route Number,	
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral d Medical Certification: To	29a. Certifier 1 Certifying P	hysician: To the best of m	y knowledge, d	eeth occurred et the	time, date end place	city or Town	ause(s) and m	anner as sta	ated. the cause(s)	
within 2 To the comple	29b. Signature and title a confidence	M D		29c. Lice	nse number	2	9d. Date signe	od (Month, L		
	30. Neme and address of person who	completed cause of deeth	(Item 23e) (Ty	pe, Pgint)	1 0		,			

State Registrar

DHMH 16 Rev 6/95

32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 2202 ANNABELLE LOUISE MERRYMAN Dec 1999 4c. County of Deeth 4e Facility Neme (If not institution, giva street and number) 4b. City. Town, or Location of Death WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours Months 1□ M 210 F Yrs 219-20-1694 92 11, 1907 WEST VIRGINIA Usuel Rasidence of Dacedent 10a Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits 1⊠ Yas 2 No WASHINGTON HAGERSTOWN MARYLAND 10a Street and Number 10f. Zip Code 10g, Citizen of What Country? 333 MILL STREET 21740 U.S.A. 12. Was Decedant Evar in U.S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva 1 Never Married 2 Married 1 Yas 2 No Specify: Specify 3 ☐ Widowed 4 ☑ Divorced Yaar or Datas: WHITE 15. Decedant's Education (Specify only highest grade completed) Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) AIRCRAFT MANUFACTURING **ASSEMBLER** 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES W. STAUBS LULA (UMN) SNYDER 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BONNIE L. VANCE/GRANDDAUGHTER 20042 JEFFERSON BOULEVARD, HAGERSTOWN, MD 21742 20b. Plece of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Othar (Specify) OLD BROWNSVILLE CEMETERY 12/22/99 BROWNSVILLE, MARYLAND 21. Signature of Funaral Service Licensee 87 Dr 22. Nama and Addrass of Facility 7606 Old National Pike BAST FUNERAL HOME Steven Danfelt Jr. Boonsboro, Maryland 21713 23a. Part1. Enter the disaasa, or complications that caused the deeth. Do not anter tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on each lina. Approximete Intarval Batween Onsat and Death Immediata Causa (Final Pressure (Brain odema Intrac rana . Increase disaasa or condition resulting in deeth) tra Cranal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events rasulting in death) Last Due to (or es a consequence of): Due to (or es a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 28 No 1 Yas 2 No 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only one) Hospitsl: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending 1 Yas 2 No Invastigation

Examiner Examiner burial-transit attending physician for use es the buria Physician/Medical signed by t Records. 2 should ! Completed page 2 s certificate Division of Vital or Attending Physician: Be Certification: To this After deeth. 24 hours after deet Funeral Director:

filled in

Hospital

within 2 o the

Physician

/Medical

Examiner

Funeral

Director

r then "naturel", or items 23s or 28s-f show the Medical Exampler must be notified at

Director

Funeral

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Completed

Be

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the Maryland

death

Peges 1 and 2 should be filed within 72 hours after nent of Heelth end Mental Hygiene.

end Mental Hygiene. Is marked other than

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Department of Heelth e Important: If item 27 is any Injury or other tra page.

Physician /Medical

Baltimore, Maryland 21215-0020

1 Yas 2 No 27. Mannar of Death 1 Natural 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifie (Check only one)

State

edicai

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2-20 405 Hag.

29d. Data signed (Month, Dav. Year)

31. Data filed (Month, Day, Year) DEC 2 1 1999

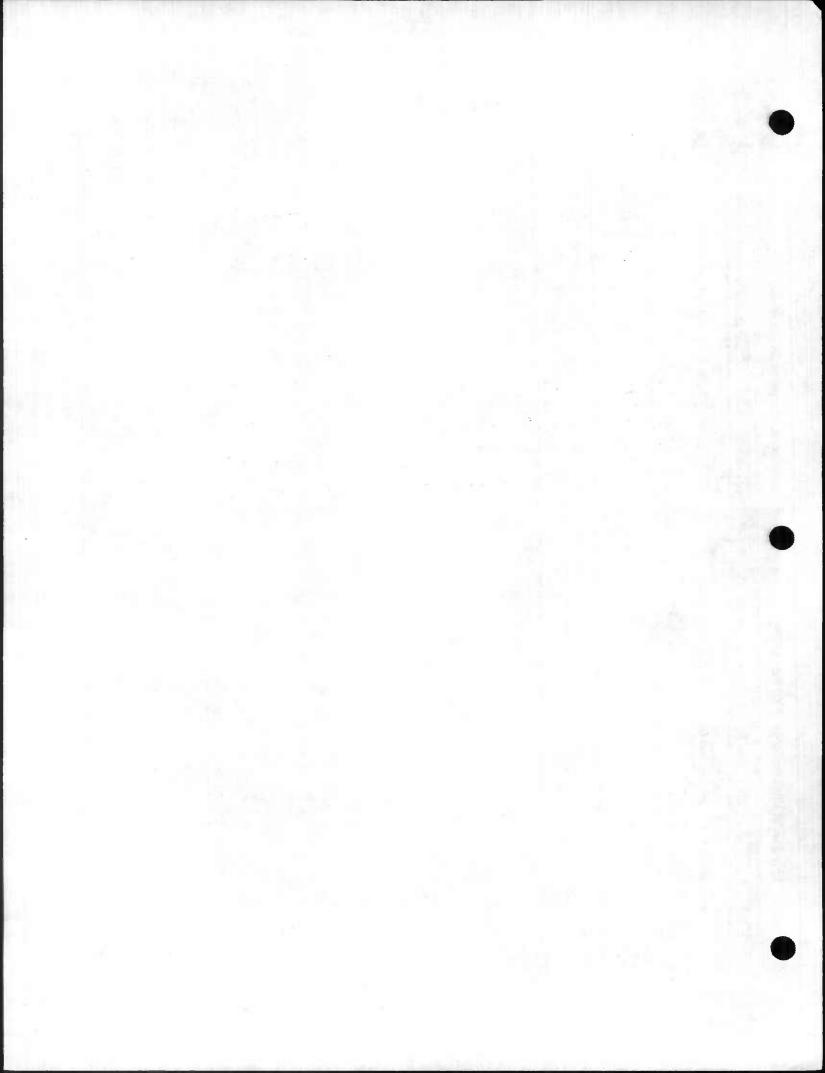
29b. Signeture and title of certified

medical Registrer's Signatura

ampus Darks.

29c. License number

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month **Physician** Philip Anthony McCabe December 9, 1999 3:40 p.m. /Medical 4e Fscility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 303-B North Colonial Drive Hagerstown Washington If Under 24 Hrs. Hours Min. 5. Sociel Security Number If Under 1 Yeer 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Deys 1⊠M 2□ F Months 219-28-3054 Yrs. Director 67 Dec. 25, 1931 Maryland Usuef Residence of Decedent the Manyland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23s or 28s-f ahow the Medical Examiner must be notified at 1 No Yes 2 No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 303-B North Colonial Drive 21742 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Detes: Korean Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic avent, the Medical Essentian once. Black, White, etc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2X No Specify: þ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) mailer newspaper company 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Herman Roland McCabe Regina Edna Dunn 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 303-B North Colonial Drive, Hagerstown, Md. 21742 Mary E. McCabe - wife 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Loudon Park Cemetery 12-14-99 Baltimore, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In deeth) noma on the /Medical Examine Examiner physician and the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disesse or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or ss e consequence of): for use as signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ should 1 24b. Were eutopsy findings avsilable prior to completion of cause of death? 24a. Wss an eutopsy performed? Completed pege 2 s 108 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical exeminer? Be 26. Place of Deeth (Check only one)

Box 68760 P.O. Division of Vital Records. certificate Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certifical. After this

Medicai Certification: To

Hospital: Other: 4□ Nursing Home 5 ☐ Aesidence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28e. Dete of Injury (Month, Dsy Year) 28b. Time of 28c. Injury st Work? 28d. Describe how Injury occurred 1 Netursi 5 Pending Investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pfece of Injury - At home, ferm, street, tectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date snd place, snd due to the cause(s) and menner as stated.

(Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner steted. 29b. Signeture a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1999

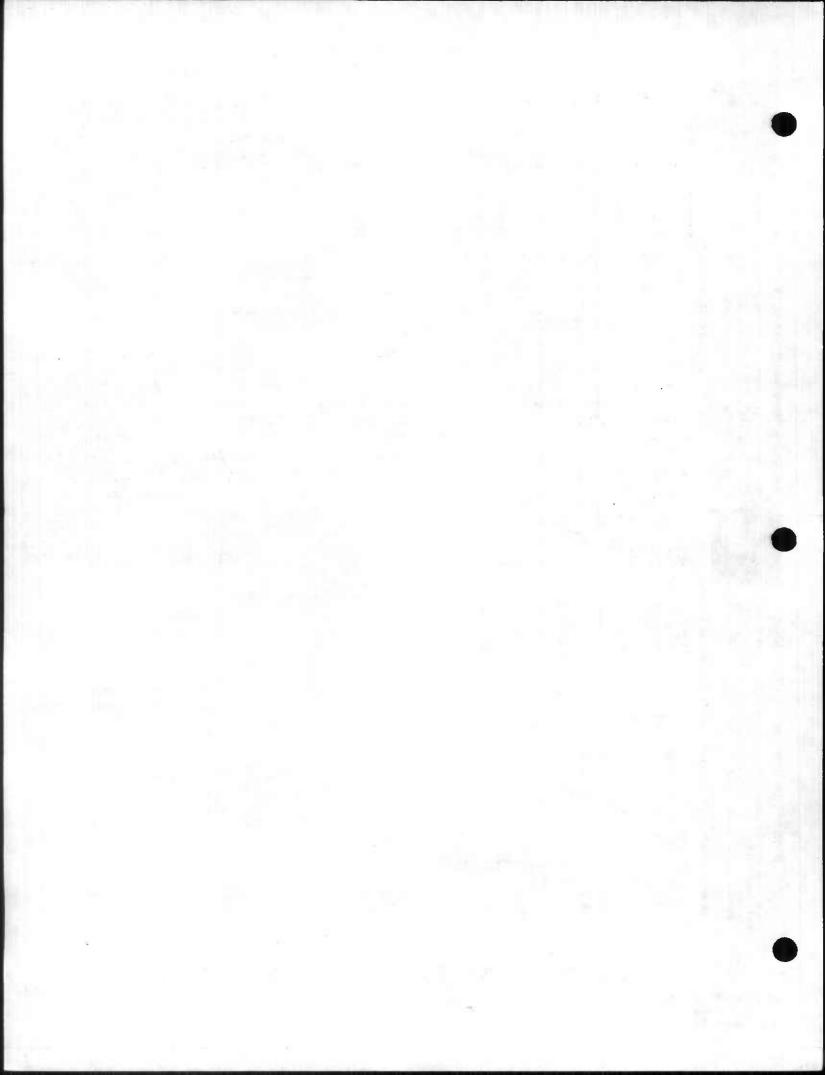
32. Registrar's Signeture

State Registrar

31. Dete filed (Month, Dey, Year)

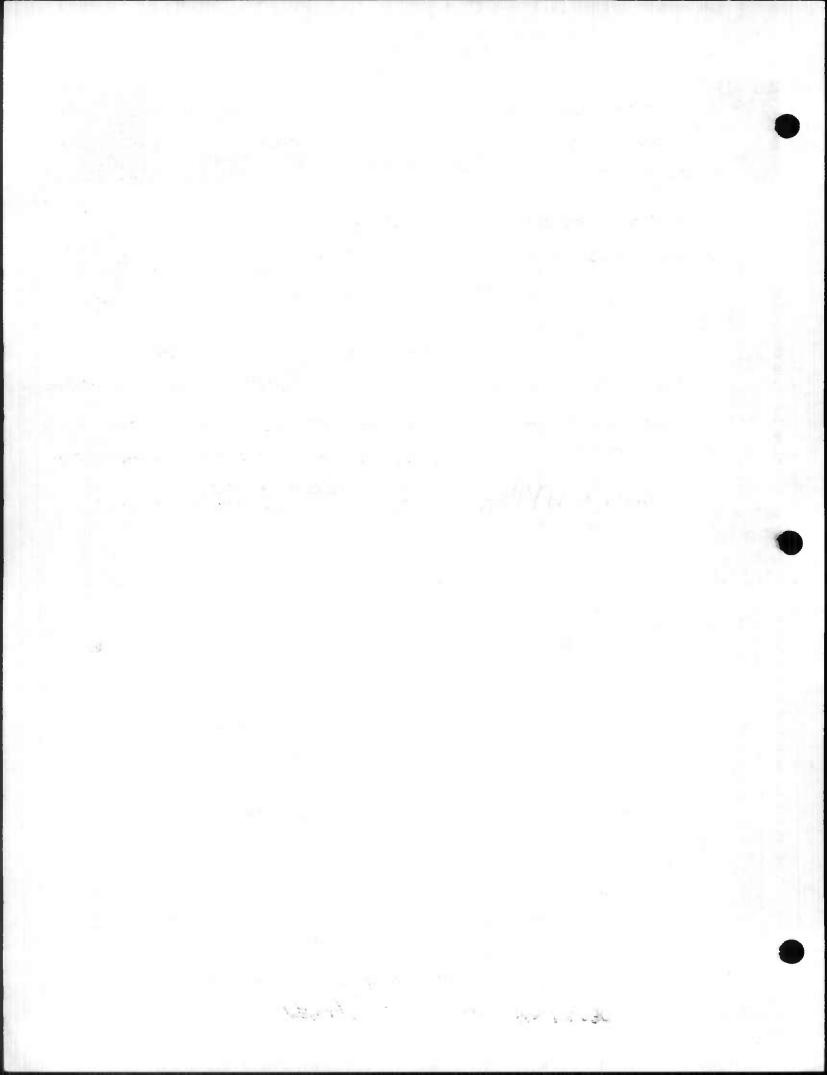
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To the Hosp within 24 hor To the Fune completely fi



State of Maryland / Department of Health and Mental Hygiene

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	Physici /Medio		VIRGINIA MAR	Y MAY					400	ber 17,19		0936
	Examir	ner	4e. Fecility Neme (If not institution, g	ive street end number)				4b. City, Town	, or Location of Dee	eth 4c. County	of Deeth	
L			Union Hospital				li I badaa d Maas	Elkt			cil	
	Funeral		5. Sociel Security Number 6 232-24-0976	. Sex 7. Ag 1	ge (In yrs. le	st birthdey) Yrs.	If Under 1 Year Months Deys		Min. (Month, L	irth Dey, Year)	Coun	blece (Stete or Foreign
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	ylend		10e. Stete 10b. County		10c. City,	Town or Lo	cation				1	0d. Inside City Limits
	e Mar	cto	Maryland Har	ford		Be	l Air					1 No Yes 2 No
	ith the	Director	10e. Street end Number				10f. Zip Code			10g. Citizen of V	Vhet Cour	itry?
	ath w	la l	109 Idlewild St	reet			2101	.4		1	USA	
	er de	Funeral	11. Maritel Stetus	12. Was Decedent Armed Forces?		. 13. V	Ves Decedent of Yes, specify Cub	Hispenic Origin an, Mexicen, P	? (Spacify Yes or Nuerto Ricen, etc.)	io- 14. Rec Bled	e - Americ	en Indien, etc.
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21215-0020	n 72 hours efter deeth with the Maryland "natural", or items 23s or 28s-f show sales Evertiner mut be notified at		15. Decedent's			18e Deced	ent's Usuel Occu	nation		16b. Kind of Bu		nite
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yla		2	Frank (nmn)	Barber				Isa	belle	(nmn)	Nic	cholette
Maryland	C (0 .0 .0		19e. Informent's Neme/Relationship	(Type, Print)		19b. Mailin	g Addrass (Stree	t end Number o	r Runal Route Num	ber, City or Town,	Stata, Zip	Code)
	Heal Heal ther		Angela Pasqual 20e. Method of Disposition	- Daughter	20b Ple	507 C	ountry W	alk Cou	rt, Bel			
Baltimore,	Pages nent of I int: if Its ury or o		1 ☐ Burial 2 ☐ Cremetion 3				eition (Neme of letary or other ple			20c. Location -		
Hin	it. Partime		4 □ Donetion 5 □ Other (Spec		HTTT		ervice C		12/20/9	9 Tows	on, M	Maryland
Ba	permit. Pages Department of Important: If It eny injury or of		2 1/ 201/24	MM		Ma	Comas Fu	neral F	Home, P.A	•		
			23a. Pert1. Entar the difference, of co shock, or heart return. List on	molications that cause	Acol the	Do not ente	17 Cokes	bury Ro	Abing	don, MD	2100	Approximete
	Physician		shock, or heart solum. List on	y one causa on each li	ne.				also of toopholory	011001,		Interval Between Onsel end Deeth
2	/Medical		Immediate Ceuse (Fine)	Asai	Lat.	Pan	Ougan and "				i,	2
	Examiner		resulting in death)	0. 10/3/1	Dua to (or	es e consequ	uence of):	4				eays.
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	tificete be executed g physician and es the buriel-transit	edicai Examiner	Sequentially list conditions,	J D.	Due to (or e	es e consequ	uence of):					
60,	be ex lcian burie	al E	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Undarlying Cause (Disaase or Injury	C								
68760,	tificete ig phys es the	edic	thet initieted evants resulting in death) Lest		Due to (or e	s e consequ	ence of):					
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P.O.	the sy th	Physician/M	Total office of the contraction	CONTRIDUCTING TO GOOTH DI	at not result	ing in the dir	derrying cause gi	vari ili Pell I.		Yes 2 No		the cause of death?
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ord	v requires thet been signed b should be det									s en eutopsy formed?	24b. We	ere eutopsy tindings elleble prior to
Records,	aw 2 s L	Completed							_		COI	mpletion of cause death?
= =	E ag	Co							1	Yes 2 PNo	1 [Yes 2□ No
Vital	ician: The certificate rector, pag	Be	25. Wes cese referred to medical examiner?	11					Daeth (Check only	one)		
o	Physician: this certific ral director,	2	1 ☐ Yes 2 ☑ No 27. Menner of Deeth	Hospital:		R/Outpetient	JL DOA		ng Home 5 Res			(v)
רס	After fune	ton	1 □Netural 5 □ Panding	28e. Dete of Inju (Month, Det	y Year)	8b. Time of Injury	28c. Inju Wo	ryet ⊮rk?]Yes 2∐No	28d. Describe	how Injury occurr	9d	
Division	deat deat	Certification:	3 ☐ Suicide 6 ☐ Could not	be	urv - At hom	a term stre		1169 2 110	28f. Location	(Streat and Numb	er or Rum	I Route Number
2	5475	FI	4 ☐ Homicida	building, ato	c. (Specify)	,,	0., 100.0., 0.1100			own, State)		
	pepita houn uners ly fille		29a. Cartifier 1 Certifying F	hysician: To the bast of	of my knowle	edga, daeth	occurred at tha ti	me, dete end p	lece, and dua to the	a ceuse(s) end ma	nnar as si	tated.
	To the Hospital or within 24 hours efter To the Funeral Dir completely filled in	edicai	one)	miner: On the basis of and menner ste	axaminatio	n and/or inv	astigation, in my	opinion, daath o	occurred at tha time	, data and placa, a	and due to	the causa(s)
	To To 1	Σ	29b. Signeture end title of certifler	X-		•	29c. Licens	se number		29d. Dete signed	(Month,	Dey, Year)
			P /	Jackden	811	11)		5322		12.17	.99	
	9		30. Neme end addrass of person who	completed ceusa of d			Print)	1-20	E017	2 22 24	21.	
	-01-		31. Dete tiled (Month, Day, Year)	32. Registry		Nach	or du	u 00	Elha	MIVID 2K	12/	
	Sta Registra		DFC 2	0 1999	March	w k	9. 16	ortal				

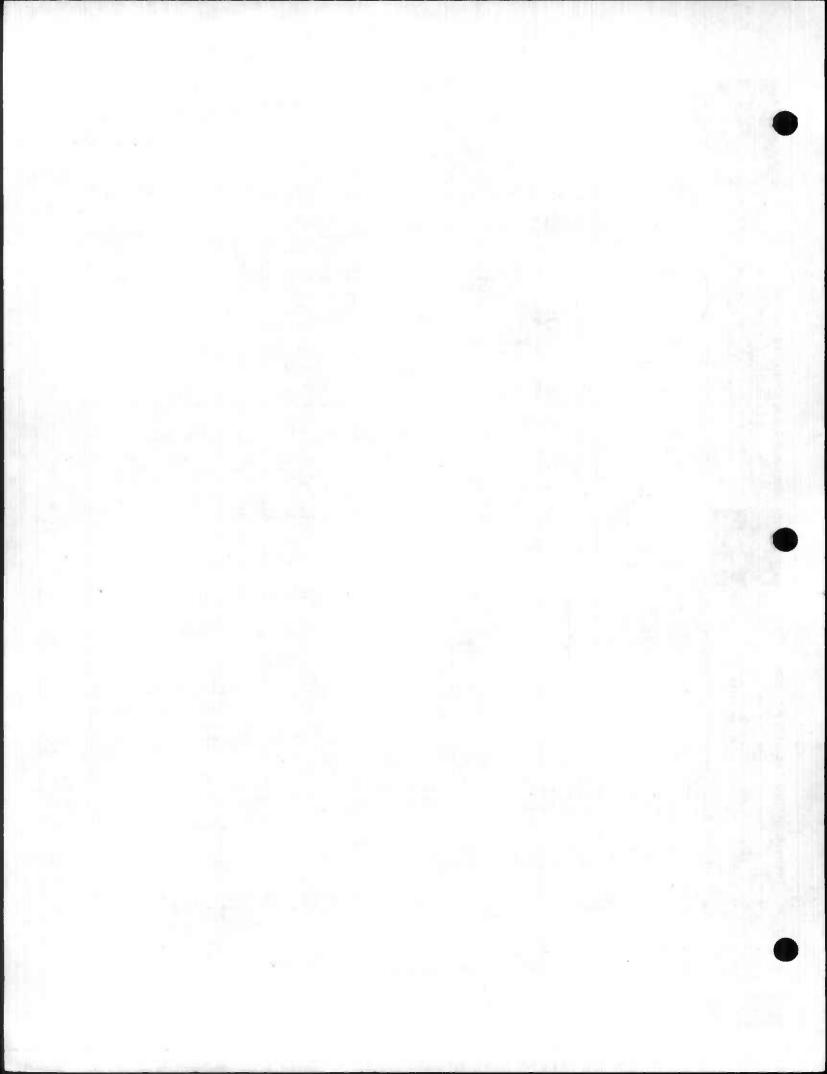


State of Maryland / Department of Health and Mental Hygiene Q

					Ce	rtificat	te of	Death		Reg. No.	1	578
Dhusia	: a	1. Decedent's Name (First, Middle, Las	t)						2. Date of De Month	ath Dey	Year	3. Time of Death
Physic /Medi		GLADYS BEARD	NEEDY						Decembe	. /-	1999	0508
Exami		4a Facility Name (If not institution, give	street and number)				4	4b. City, Town, or	Location of Deat	4c. County	of Death	
		WASHINGTON COUNT	Y HOSPITA	L				HAGER	STOWN	W	ASHIN	GTON
Funeral		Social Security Number 6. Security Number	ex 7. Ag □M 2⊠F	e (In yrs. la		If Unde Months	r 1 Year Days	If Under 24 Hr		th	9. Birthp	lace (State or Foreign
Director		213-18-8389	LIM ZEIF	85	Yrs.					1914		NSYLVANIA
Pu a		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or L	ocation					10d. Inside City Limits	
eho e	č	· ·		roa. ony,	10001012	Journal	D001	-07070			1.	1⊠Yes 2□No
7 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	Director	MARYLAND WASHING	TON			404 75		NSBORO		10- Chi of 1	1401 C	
E 9 E						101. 2.1	p Code	0.4.7.4.0		10g. Citizen of		
-0020 hours after deeth with the Maryland urat', or frems 23a or 28a-f show at Examiner must be notified at	Funeral	423 NORTH MAIN ST	REET 12. Was Decedent	Ever in II C	12	Was Dags	dont of N	21713	Specific Vac or No		J.S.A	
front front	'n	1 Never Married 2 Married	Armed Forces?			If Yes, spe	cify Cuba	an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	Bla	ck, Whita,	
1,0 at	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2 ⊠ No	Specify:		Specif		IITE
72 hours		15. Decedent's Ed		T	16a. Dece	edent's Usu	al Occup	ation		16b. Kind of B		
215- oln 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or !	F.1)	(Give	kind of wo DO NOT u	ork done ise retired	during most of wo	orking			
21215-0020 within 72 hours af plens. Then natural; or	E	12	College (1-401:	0+)	OV	NER A	AND (PERATOR		HO'	TEL	
7 6 9 7	Be C	17. Father's Name (First, Middle, Last)						18. Mother's Na	me (First, Middle	Maiden Sumar	ne)	
Maryiand d 2 should be flight and Mental Hy 7 is marked oth	ToE	ROBERT LEE BEARD						URILLA	A. GOSSA	RD		
Maryis d 2 should h end Mer 7 ie marke traumatic		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mail	ing Addres	s (Street	and Number or F	iural Route Numb	er, City or Town	, State, Zip	Code)
7 2 9 6 7		JUNE E. KEYES/DAU	JGHTER		514 I	BEAVE	R CRI	EEK ROAD	, HAGERS	TOWN, M	ARYLA	ND 21740
or Heal		20a. Mathod of Disposition		20b. Pla	netery, cre	osition (Na	me of other place	ce)	Date	20c. Location	- City or To	wn, Stata
altimore mit. Pages 1 opermant of He portent: if item y injury or oth		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		SMT	THSBU	RG CR	EMAT	ORY 1	2/19/99	SMITHS	BURG	MARYLAND
Baltimo pemit. Page Depertment of important: If eny injury or		21. Signature of Funeral Service Licen	500	10111				ss of Facility				
D e de la constanta		P. SA DANGELLE J.	K., Steven Dar	folt	Tr BA	AST FU	JNER	AL HOME		d Nation		
		23a. Part1. Enter the phoses, or composhock, or heart failure. List only of				iter the mor	de of dyir	ng, such as cardia	ic or respiratory a	rrest,	yranu	Approximate Interval Between
Physician /Medical Examiner	Jer.	Immediate Cause (Finat disease or condition resulting in death)	e. Cere	Due to (or	vo as a conse	quence of)	on	acie	lent.		1	3 days
cords, P.O. Box 68/60, requires that the death certificate be executed been signed by the attending physician and should be detached for use as the buriel-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or a				receo	anes		1	
death cert	Physician/N	Part II. Other significant conditions co	d intributing to death b	ut not resulting in th		he underlying cause given in Part I.		ren in Part I.	23b. Did	obacco use contribute to the cause of de		the cause of death?
that the de detached	by Phy	chronic a	treal	file	ull	alie			10	Yes 2□ No	3×Prot	bably 4 Unknow
N = 0	Completed b			V					24a. Was	an autopsy omied?	ave	ere autopsy findings ailable prior to mpletion of cause death?
VICAL MEC stelen: The law a certificate has b director, page 2 a	Eo								100	Yes 2□No	10	Yes 2 No
VITAL Melen: T certificat irector, pa	Bec	25. Was case referred to medical						26. Place of Dr	eath (Check only	one)	J	
Of VITA Physician: this cartific and director,	ToB	examiner?	Hospital:	ent 2DE	R/Outpatie	nt 3□ D	OA Oth	or-			ner (Specifi	v)
To the Nospital or Attanding Physicien: The is within 24 hours effected. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tima of Injury W			28c. Injur Wor	28d. Describe how injury occurred Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred Nork? 1 Yes 2 No					
LIVISION Lai or Attanding re effector: Affector: Affector: Affector has been been by the fune	edical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At hom c. (Specify)	ne, farm, si	treet, factor	y, office		28f. Location (City or To	Street and Numi wn, State)	ber or Rura	il Route Number,
To the Hospital within 24 hours To the Funeral completely filled	dicai	29a. Certifier (Check only one) Certifying Phy one)	raician: To the best of iner: On the basis of and manner sta	axaminatio	edge, deal on and/or in	th occurred nvestigation	at the tir	ne, date and plac pinion, death occ	e, and due to the curred at the time,	cause(s) and m date and place,	anner as st and due to	ated. the cause(s)
To the Foundation of the Country of	×	29b. Signature and title of certifier	11					e number		29d. Date signe	ed (Month,	Day, Year)
. ,,,,		n4	la V				D 3	2518		12/19	9/99	
	ŀ	30. Name and address of person who o	ompleted cause of d	leath (Item 2	23a) (Tvna			-			11/	
		Dr. Guedene	+ 100	Ger	1 .			o V	redysv.	110 1	nd	
Sta	ite	31. Date filed (Month, Day, Year)	32. Régistr	ar's Signatu		1	ra ri	- J.	204201	116, 1	. 0	
Regist	8000	DEC 2 0 199	9 1941	Janes J	19.	ho	an Il	1				

DHMH 16 Rev 6/95

Needy, Gladys



December 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street end number) 4c. County of Death Examiner Washington County Hospital Washington Hagerstown If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer **Funeral** Days 10M 2XF Months 84 Yrs. 173-03-1029 Director Jan. Usual Rasidence of Decedan 10a State 10h County 10c. City, Town or Location 28a-f show Directo Franklin Greencastle 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ъ "natural", or Itama 23a 47 Williamson Ave. 17225 U.S.A. 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 Yes 2 No If Yas, Give Yeer or Detes: 1 Never Merried 2 Married Maryland 21215-0020 1 ☐ Yes 2 XNo þ 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Book Store & College 12 Secretarial/Bookkeeping 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) 1 and 2 should be fill Health and Mental H Iem 27 is marked oth 96 Philip O. Crider Fannie Statler 19e. Informant's Neme/Reletionship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Department of Health Important: If Item 27 I J. Hoke Ommert/Husband Penn Hall, 1425 Philadelphia Ave. Chambersburg, Pa. 17201 Saltimore, 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Pages 1 Suriel 2 □ Cremetion 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) injury or Cedar Hill Cemetery 12/14/99 Greencastle, Pa. 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Zimmerman And Son Funeral Home Inc. 45 S. Carlisle St. Greencastle, Pa. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haert tailure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final diseesa or condition resulting in death) Examiner Examiner physician end the burial-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or es e consequence of) peritonitis Due To Box 68760 Physician/Medical Ommert

Pert ti. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Mae

Ommert

1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case raterred to medical examinar? 26. Placa of Death (Check only ona) Hospitel: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yes 20 No 1 Dippatient 2 ER/Outpatient 3□ DOA 27. Mannar of Death 28d. Describe how Injury occurred 28a. Date of triury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 Neturel 2 Accident 5 Pending investigation 1 Yes 2 No 28t. Location (Street and Number or Rural Route Number, City or Town, Stele) 6 Could not be determined 28e. Plece of Injury - At home, term, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 - Homicide

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Dete of Death

Dev

3. Tima of Death

9. Birthplece (State or Foreign Country)
Penna.

White

17225

23b. Dtd tobacco use contribute to the cause of death?

Approximata Intervel Between Onset end Death

10d. Inside City Limits

1 Yes 2 □ No

Certifying Rhysician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the causa(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the iner: On the basis of examinetion and/or investigation, in my opinion, death occurred et tha time, data and place, and dua to the cause(s) and menner steted. (Check only one)

29c. License number 29d. Date signed (Month, Day, Year)

30. Neme end address of # ino completed causa of death (Item 23a) (Type, Print) ms

State Registrar

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Completed

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n 24 hours after death.

Funeral Director: Aft
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To the Hosp within 24 hor To the Fune completely fi

Division

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Hospital

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31. Dete tiled (Month, Day, Year)

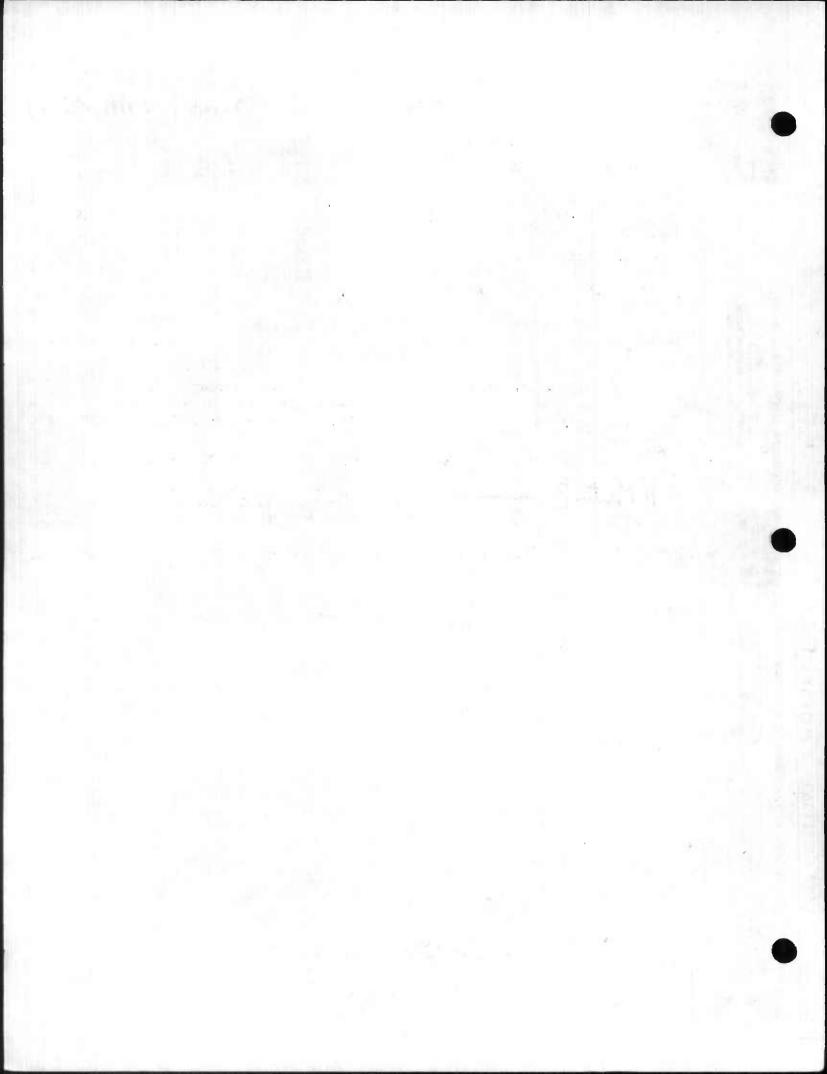
29b. Signeture and the of certif

1. Decedent's Neme (First, Middle, Last)

Physician

/Medical

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day Year December 13, 1999 6:14 PM Betty Magnuson O'Brien 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Fallston Harford Fallston General Hospital If Undar 1 Yaar If Under 24 Hrs. Hours Min. 5. Social Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) 1 □ M 257 F Months Days Yrs. Apr. 26, 1922 Minnesota 471-20-2688 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 1 ☐ Yes 2 🕱 No Maryland Bel Air Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21014 USA 223 East Ring Factory Rd. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2♥ No If Yes, Give Yaar or Datas: 14. Raca - American Indian, Black, White, etc. Was Dacedent of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1 ☐ Naver Mamied 2 ☑ Married 1 ☐ Yas ≥ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Nama (First, Middle, Last) Anna Elvera Lance Oscar Magnuson Carl 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 223 East Ring Factory Rd., Bel Air, Maryland 21014 Samuel W. O'Brien / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 12-17-99 Towson, Maryland ▲ □ Donation 5 □ Other (Spacify) 21, Signal McComas Funeral Home, P.A. Comas 1317 Cokesbury Road, Abingdon, Maryland, 21009 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or hear the ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final Arterioschrolic Cardioveswar disusc disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) Due to (or as a consequence of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CARLINOMA PANCRUAS 24b. Were autopsy findings available prior to completion of causa of death? 24e. Wes an autopsy colon Cancer performed' Hypertungion 1 Yes 2 No 1 Vac 28 No 25. Was cese referred to medicel 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 11X Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h. Time of 28c. Injury at Work? 5 Pending Investigation 1 X Natural 1 Yes 2 No 2 Accident

Examiner physician and the burial-transit that the death certificate be executed P.O. Box 68760. 65 signed by the a Division of Vital Records, The law requires certificate has t liractor, pege 2 s Hospital or Attending Physician: diractor this funeral After death. aftar death To the Hospital or A within 24 hours aftar To the Funeral Direcompletaly filled in b edical

Physician

/Medical

Examiner

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by

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Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. Important: If Itam 27 is marked other than "naturel", or items 23a or 28a-f ehow any Injury or other traumatic event, the Medical Examiner must be notified at

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Physician/Medical à Completed Be To Certification:

3 Suicide

4 Homicide 29a. Certifier (Check only one)

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29b. Signature and title of certifield OCME DME

29d. Data signed (Month, Day, Year) December 13, 1999

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

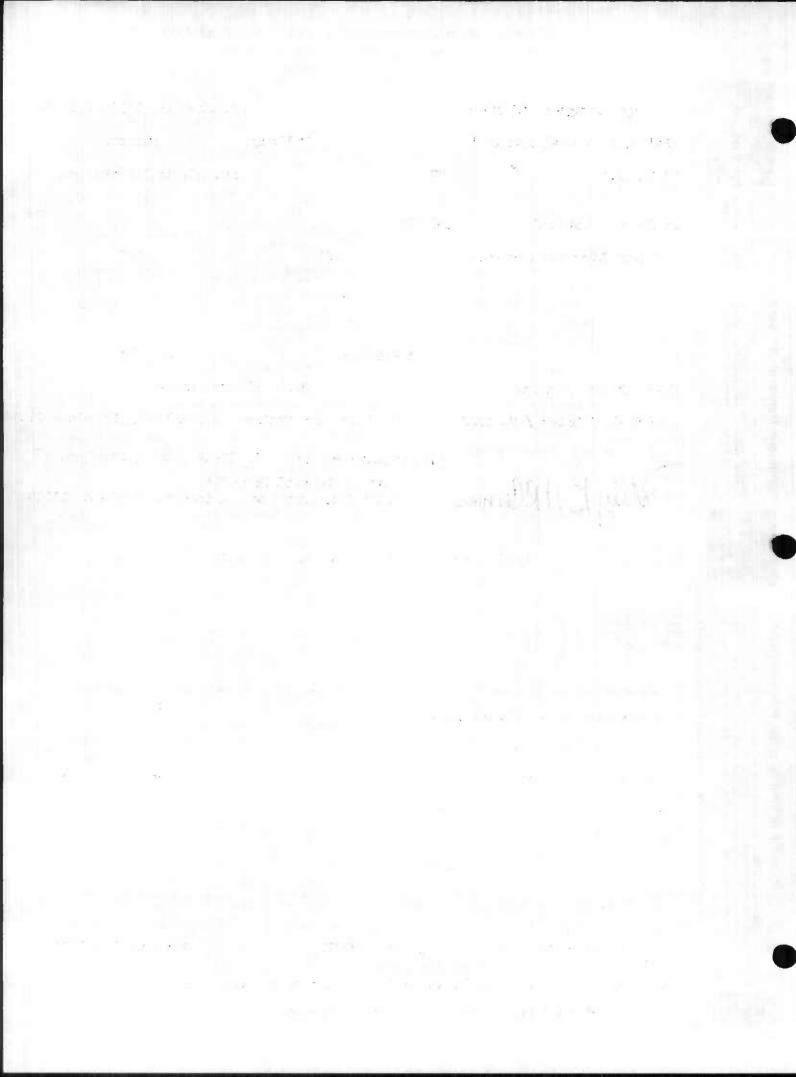
5. PARSHU M- D 218 fulford ANE 32. Registra s Signatura 31. Date filed (Month, Day, Year)

1999 ▶

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BELAIR MO 21014

State Registrar



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		1 - FOR STATE REGISTRAR	STATE OF MARYLAND / DEPARTI	MENT OF HEALTH AND	MENTAL HYGIENE REG. NO.	
)		1. DECEDENT'S NAME (First, Middle, Lasy) CECTIC	rillip Robert	son	2. DATE OF DEATH DAY 12 15	YEAR 3. TIME OF DEATH 99 1:45 p. M
pinous		4. SOCIAL SECURITY NUMBER 088-42-5684 9a. FACILITY NAME (If not institution, give stre	1 ⋈ M 2 □ F 48 YRS. M	FUNDER 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTN (Month, Day, Year) 2-10-51	a. BIRTHPLACE (State or Foreign Country) N. Y
1, 2, 3	CTOR	30828 HAMPOGEN	AUE 1	Rincess Anne	Seath Sec. COU	OMERSET
permit. Pages	L DIRECTOR	10a. STATE 10b. COUNTY	_ 1.2	incess Anne		10d. INSIDE CITY LIMITS? 1 2 YES 2 NO
-15	FUNERAL	308 28 Hampden	12. WAS DECEDENT EVER IN U.S. ARMED	101. ZIP CODE	33	ZEN OF WHAT COUNTRY? U.S
ending physic as the burial	ВУ	1 Never Married 2 Narried 3 Widowed 4 Divorced	FORCES? 1 YES 2 DONO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPAI If yes, specify Cuben, Mexico 1 YES 2 XLNO Specif		14. RACE — American Indian, Black, White, etc. Specify: Black
spital or att	COMPLETED	15. OECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12)		done during most of working	New York T	elephone Co.
ed by the hould be detach	BE COI	17. FATHER'S NAME (First, Middle, Last) Clifford Robertso		18. MOTHER'S NA		nan
ay be retained page 5 should t be notified	5	190. INFORMANT'S NAME (Type/Print) Anna Mac Robeits 20a. METHOD OF DISPOSITION	on 8561 M	: HORD Long RD	Manokin MD	21834
age 6 ma director, i		1 Burial 2 A Cremation 3 Remon	SAlasbuen	Cematory		sbuey, MD
after death. Page 6 m by the funeral director, smoval.		Anthony 9	2. Ward	30639 Hampden	Ary Princess Lo	omo
within 24 hours upletely filled in the cremation, or re-		23. PART 1. Enter the disessed or co- ahock, or haart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death)	mplications that caused the death. To not st only one cause on each line. ACGU 'NO L' MU DUE TO (OR AS A CONSEQUENCE OF):	1	to e M g	Approximats interval Between Onset and Daath
e be execusician and infor to but traumative	RTIFICATION	Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events	DUE TO (OR AS A CONSEQUENCE OF):			
death c attend ental Hy	S	resulting in death) LAST				
20-	MEDICAL	TATE SIGN SIGNICAL CONDITIONS	contributing to death but not reaulting in t	ne undarlying cause given in	Part i. 24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
has been Dept. of 1 23 sh		DID TOBACCO USE CONTRI 25. WAS CASE REFERRED TO MEDICAL	BUTE TO CAUSE OF DEATH YES 28. PLACE OF DEATH (N D	10,163 20,100
ICIAN: The ertificate h the State I	IYSICIAN		HOSPITAL: I Inpetient 2 ER/Outpetient 3 DOA 4	THER: Nursing Home 5 Healdence		
DING PHYS After this of death with	ВУ РНУ	1. Natural 5 Pending 2 Accident Investigation	26e. DATE OF INJURY (Month, Day, Year) 26b. TIME O INJURY	WORK? M 1 YES 2 NO	26d. DESCRIBE NOW INJURY OCC	URED
TTEN TOR: after	ETED	3 Suicide 8 Could not be 4 Nomicide determined	26s. PLACE OF INJURY — At home, 1erm, stre- building, etc. (Specify)	et, factory, offica	281. LOCATION (Street and Number City or Town, State)	or Rural Route Number,
Z 32 =	COMPL	2 MEDICAL EXAMINER:	AN: To the best of my knowledge, death occurred a On the basis of examination and/or investigation, I			
TO THE HOSP! TO THE FUNER DE filed within IMPORTANT:	TO BE	296. SIGNATURE AND TITLE OF CERTIFIER (30. NAME AND ADDRESS OF PERSON WHO	COMPLETEO CAUSE OF OEATN (ITEM, 27) (Typo, Pri	29c. LICENSE NUN	74 12	SIGNEO (Month, Day, Year)
		A COCCEY, 31. DATE FILEO (Month, Day, Year)	32. REGISTRAR'S SIGNATURE	ad, Salve	omy, md El	804
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death Month Dey DECEMBER 1555 Dale Charles RICHARDS 21 4a Facility Neme (If not Institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Wa Munder 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) Washington 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 6. Sax Months Days 110 M 2□ F Aug. 16 1925 Pennsylvania 208-16-8366 74 Usuel Residanca of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No W. Va. Berkeley. Falling Waters 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 140 Broadview Court 25419 U.S.A. 12. Was Decedant Evar in U.S. Armed Forces? 1 12 Yes 2 No If Yes, Give Year or Data: 944-52 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Bleck, White, etc. 1 Never Merried 20 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

140 Broadview Court

22. Name end Address of Fecility

415 E. Wilson Blvd.

Custodian

20b. Plece of Disposition (Name of cemetery, cremetory or other place)

Norland Cemetery

23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line.

Phenonia

Due to (or as a consequence of):

16b. Kind of Business/Industry

Falling Waters, W.Va. 25419

12/24/99 Chambersburg, Pa.

Minnich Funeral Home

18. Mother's Neme (First, Middle, Maiden Sumeme)

Bertelle Yeager 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

County Government

20c. Location - City or Town, State

Hagerstown, Maryland 21740

DEC 22, 1999

Approximete Intervel Between Onsat end Death

2-3 was

Physician /Medical Examiner

Department of Health a Important: If them 27 is any injury or other tra

Physician

/Medical

Examiner

10a. Stata

15. Decedant's Education (Specify only highest grade completed)

Elementery/Secondery (0-12) 12

17. Father's Nema (First, Middle, Last)

Dreher Richards

20a. Method of Disposition

Immediata Cause (Finel disease or condition resulting in death)

19e. Informent's Neme/Reletionship (Type, Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signeture of Funeral Service Licensee

Leanna Richards - Wife

N Burial 2 ☐ Cremetion 3 ☐ Ramoval from State

College (1-4or 5+)

0

teste mo

30 Nema and address of person who completed cause of death (Item 23a) (Type, Print)

Dr Datta 33 4 Mill Strey

334 Mill

32. Registrar's Signeture

Funeral

Director

r 28a-f show notified at

finer must be r b

"natural", or I

Hygiene.

Pages 1 and 2 should be nent of Health and Mental

ä

filed within 72 hours after

Saltimore, Maryland 21215-0020

Director

Funeral

ģ

Completed

Be

Vital Records, P.O. Box 68760, Attending Physician:

ic HAROS

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2

Examiner Physician/Medicai b Completed Be edicai Certification: To after death filled in by within 24 hours a To the Funeral D

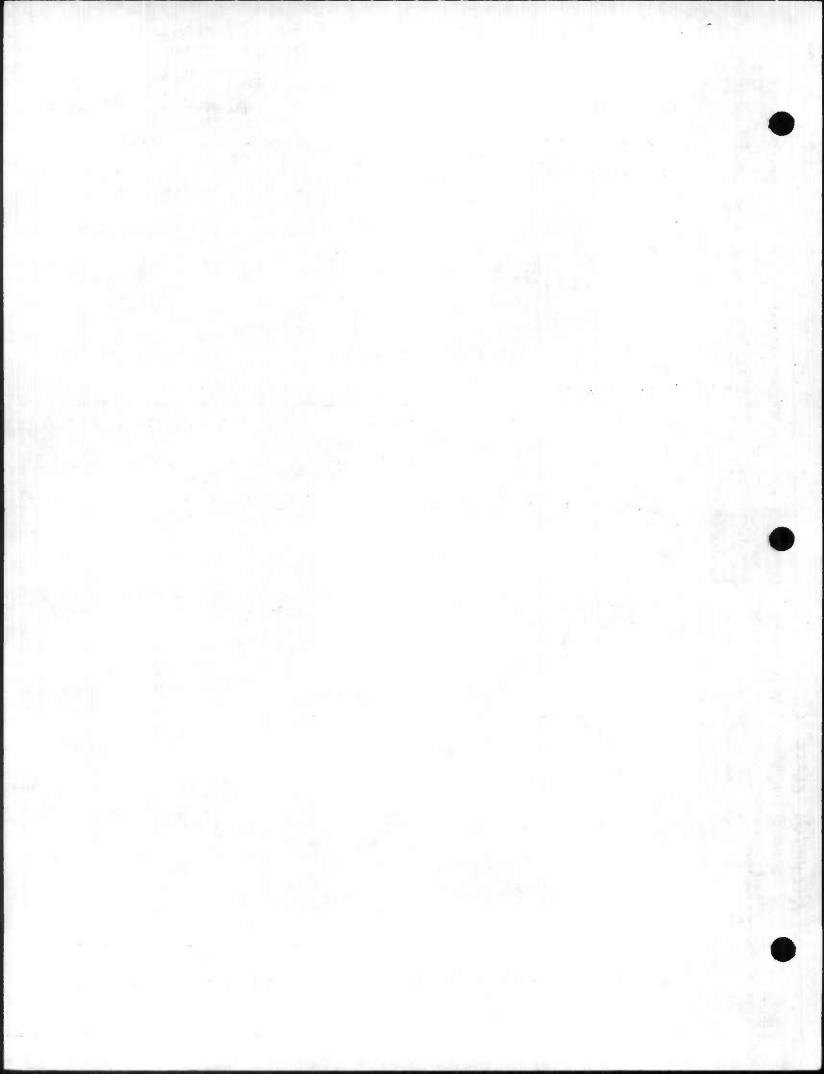
	b						
Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Ceuse (Disease or injury		or es e consequence o	0():				
that initiated events resulting in death) Last	Due to (or as e consequence o	(f):				
	d	_		_			
Part II. Other significant conditions on	entributing to death but not rec			23b. Did tobecco uss co	antributs to the cause of death?		
***	your shade			24a. Was en eutopsy performed?	24b. Wera autopsy findings evailable prior to completion of causa of death?		
25. Wes case referred to medical			26. Place of De	eath (Check only one)			
examiner? 1 Yes 2 No	Hospitel: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)		
27. Menner of Death 1		28b. Time of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occur	rred		
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	nome, farm, street, fectify)	28f. Location (Street and Numi City or Town, Stete)	8f. Location (Street and Number or Rural Route Number, City or Town, State)			
				e, and due to the cause(s) and m urred et the time, date end place,			
29b. Signatura and title of certifier			29c. License number	29d. Date signe	ed (Month, Day, Year)		

D 18019

Hagerstown.

State Registrar 31. Dete filed (Month, Dey, Year)

DEC 23



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Edmund Ramia Ronald 14, 1999 7:00 AM December 4a. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 403 Talbot Avenue Cambridge Dorchester If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Yaar 7. Age (In yrs. lest birthdey) Birthplace (Steta or Foreign Country) Months Days 214-26-2600 70 Yrs Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas ZONO Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 5516 Ross Neck Road 21613 US 12. Was Decedent Ever in U,S. Armed Forces? 1. December 2 □ No If Yes, Give Yaar or Dates: 51-53 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes XX No Specify: White 3 Widowed WDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Mechanical 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Contractor Steamfitter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Frederick A. Ramia, Sr. Lillian Polson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel W. Ramia 30071 Southampton Bridge Road Salisbury, MD 21804 Son 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 12/17/99 Dorchester Memorial Park Cambridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility Thomas Funeral Home, P.A. of Funeral Sewica Licensee 700 Locust Street Cambridge, Maryland 21613 Enter the disaasa, or complications that caused tha death. Do not antar tha mode of dying, such as cerdiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Intarval Batwaen Immediate Cause (Final 5 months disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown 24a. Was an autopsy

Physician /Medical Examiner

physician end the buriel-transit

signed by I

certificete

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

Medical Certification: To

P.O. Box 68760,

Division of Vital Records,

Physician

/Medical

Examiner

Funerai

Director

28a-f show

Director

Funerai

þ

Completed

Be

traumatic event, the Medical Examiner must be notified at

"natural", or Items 23a or

Hygiene.

permit. Pages 1 and 2 should be the Department of Health and Mental Hy Important: If them 27 is marked oths any injury or other traumatic event.

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, laading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Physician/Medical Completed 25. Was cese referred to medical Be

1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

's House

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work?

5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicida 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Yaar)

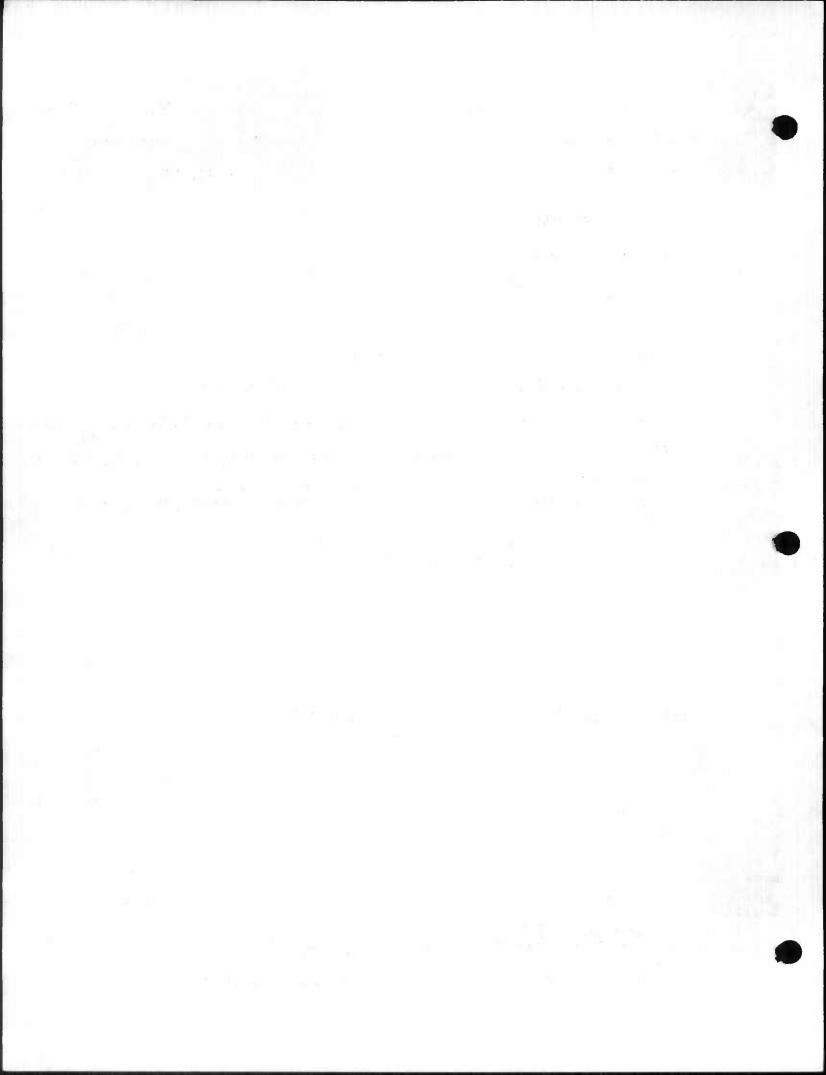
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David G. Oliver MD 503 Dutchman's Lane Easton, Maryland 21601 31. Date filed (Month, Day, Yeer)

State Registrar

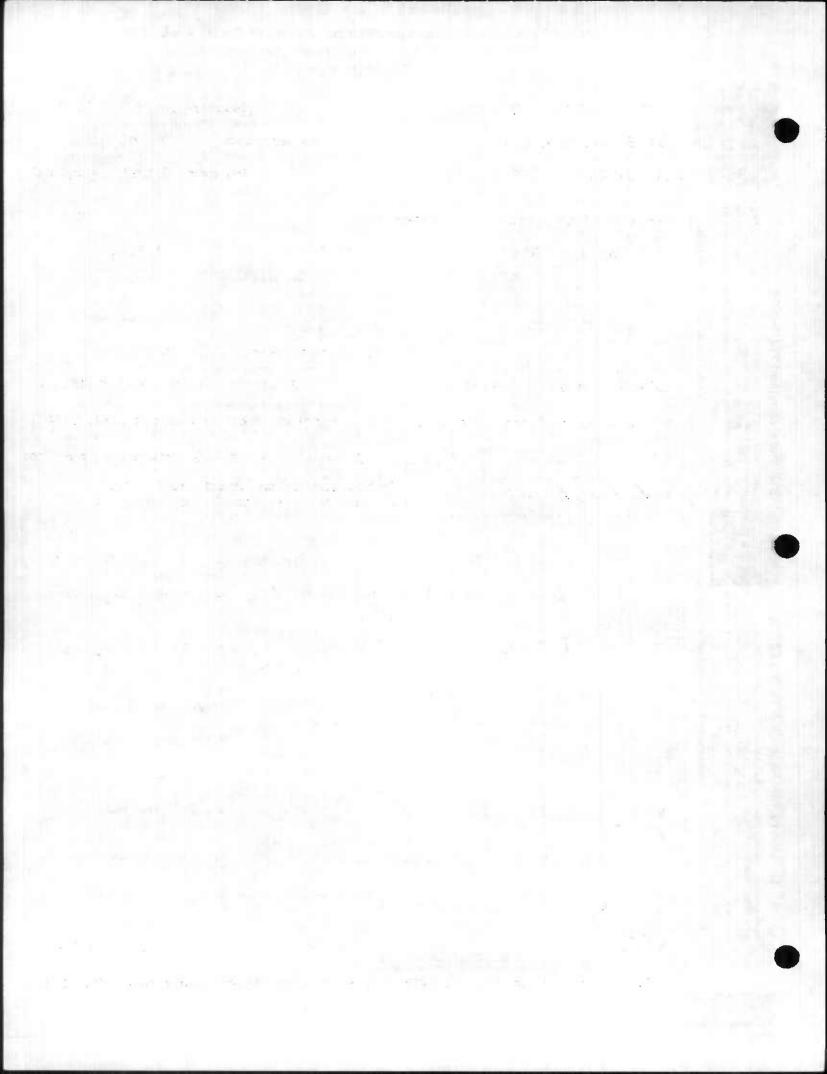
DEC 1

32. Registrar's Signature



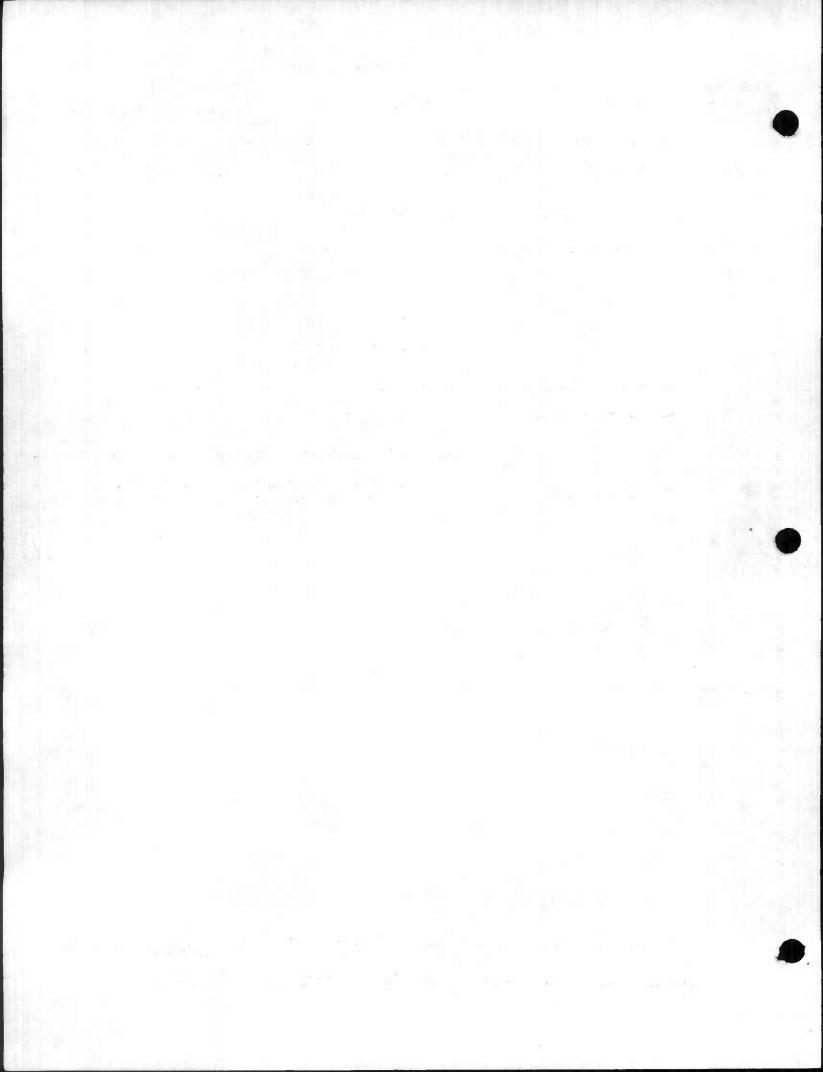
State of Maryland / Department of Health and Mental Hygiene

						Ce	rtificat	e of	Death		Reg	. No.	17	1004
			1. Decedent's Name (First, Middle, La	ist)							2. Dete of Death	Day	Vant	3. Time of Death
	Physicia - /Medic		LOIS HELEN	ROWLA	ND						December	16,199	Yeer 99	0753
	Examin		4a Facility Nama (If not institution, git						4b. City, To	wn, or Lo	ocation of Death	4c. County of		
40	=/		1415 Hamilto	n Blvd.					Hage	rst	own	Wasl	hing	ton
	Funeral				e (In yrs. les	t birthday)	If Under Months	1 Year Devs	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Y	(par)	9. Birthpl Count	ece (Stete or Foreign
L	Director		213-18-9234 Usuel Residence of Decedent	1□M 27□F	82	Yrs.	MONTHS	Deys	nours	IVIII I.	Septembe	r 6,191	17	Maryland
	yland Mow		10a. State 10b. County		10c. City, 1	Town or Lo	ocation						10	d. Inside City Limits
	he Mar	ector		Ington	На	ager	stow				140	0		1 Yes 2 No
	23e or 2	Funeral Director	10e. Street and Number 1415 Hamilton	Blvd.				2174				U.S	. A .	
21215-0020	72 hours after death with the Maryland natural', or Items 23a or 28a-f show sical Examinat rougher collined	þ	11. Meritei Stetus)(Naver Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 If Yes, Give Yaar or Datas:			Wes Deced if Yes, spec 1 ☐ Yas	cify Cub	en, Mexicar	i, Puarto	ecify Yes or No- Rican, etc.)	Bieck	White,	otc.
5-0	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation		(Give	dent's Usua	rk done	during mos	t of work	ina 16	b. Kind of But	siness/Ind	ustry
21		nple	Elementery/Secondery (0-12)	College (1-4or 5	5+)	life.	DO NOT u	se retire	d)					
		5		4		Cle	erk S	Ster	nogra	-		Rail		
and	be filed tal Hyg d other event,	Be	17. Fethar's Neme (First, Middle, Las								e (First, Middle, Ma			
Vla		2	Robert Rosc	oe Row	land				Je	SSI	e Sus	an H	olle	nberger
Mary	d 2 should th and Mer 7 Is marke traumatic		19a. Informent's Name/Relationship								el Route Number, (
Z	CENE		Richard F. Mo	Grory Fr	iend 2	152 W	lest W	lash:	ingtor	1 Sti	reet, Hag	erstow	n, Mo	1. 21740
altimore	S + = 0		20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ 4 □ Donetion 5 □ Other (Speci		cem	etery, cre	osition (Ner metory or o	other ple	ce) tery	12		C. Location - C Hagers		wm, Stete , Maryland
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of Funaçal Service Lice			1	Andre	w K.		man	Funeral H			M.J. 04740
			23e. Pert1. Enter the disease, or con shock, or heart feilure. List only	plications that caused	the deeth	Do not en	4U Eas	st A	ntiet	am S	treet, Ha	gersto	wn,	Md. 21740 Approximate
	Physician /Medical		shock, or heert feilure. List only Immediate Cause (Final											Intervel Between Onset end Deeth
	Examiner		diseese or condition resulting in death)	· Conge	estiv	- 17	tean	4	ta	luc	٤		es +	- J-7 day
		ē		10 1	Due to (or e	s e conse	quence of):				200		-	
	Junsit Insit	Examiner		b. A.T.	er (OS	cle	10 to E	_ 4	lay_	7	2 L Sear	-	7	ew-
-6	exect n end	Exa	Sequentielly list conditions, if eny, leeding to Immediate cause. Enter Underfying Couse (Disease or Injury C.											
68760	law requires that the death certificate be executed es been signed by the attending physician end a 2 should be deteched for use as the buriel-transit		Ceuse (Diseese or Injury that Initiated events											
88	phy s the	edical	resulting in deeth) Lest	Seure	Ch 10	s a consec	quence on:	5 th	wich	de 1	solmong years			
~	certifica inding pl use as t	2		d				7	150	an			10	
Bo	attendi	Physician/						-			(
0	res that the designed by the a	iysi	Pert II. Other significant conditions	contributing to death b	ut not resulti	ng in the u	inderlying o	cause gi	ven in Part	l.				the cause of death?
P.0	that the ed by dete										1 TY Yes	2□ No	3 Prot	ably 4 Unknown
Records,	sign d be	d by									24e. Wes en	autoney	24b. We	re autopsy findings
0	been signature	Completed									performe		ave	elleble prior to
Sec.	hes t	Idu											of o	deeth?
=	E seg	S									1 ☐ Yes	215 No	1 🗆	Yes 2□ No
Vital	Physician: The this certificate ral director, pag	Be	25. Wes case referred to medical exeminer?							e of Deat	h (Check only one,)		
of	this c	2	1 Yes 2 No	Hospitel: 1 Inpatie		R/Outpatie	-	JA		ursing Ho	ome 5 Residen)
ion	D 0 2	ation:	27. Manner of Deeth 1 Neturel 5 Pending 2 Accidant investigation	28a. Date of Inju (Month, De	y Year) 28	8b. Tima o Injury	of M	28c. Inju Wo 1 □	ryet rk?]Yes 2□	No	28d. Describe how	v Injury occurre	ed	
Division	or Attending strender.	Certification:	3 Sulcide 6 Could not to determine determined	256. Piece of inj	ury - At home c. (Specify)	e, farm, st						ion (Street end Number or Rural Route Number, or Town, Stete)		
	Hospita 24 hours Funeral tely fille	edical C		nyalclan: To the best of minar: On the basis of end menner ste	f examination									
	within 2 To the	Me	29b. Signature and title of certifier				29	c. Licen	se number		290	d. Dete signed	(Month,	Dey, Year)
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		-	2 clward W	W , Hoza	-	- 1 4		0 -)	- /	1	1 ()
-			30. Name and address of person who	•				Jest	insta	n C:	maat 11.		100 8.4	1 04740
			31 Date filed (Month Pay Year)	itto III	MD er's Signatur		VEST V	wasn	TIIGTO	II ST	reet, Hag	yerstow	//1, M	u. 21/4U
	Sta Registr	_	DEC 21	99	al alpharon	19.	de	rou	2					



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		Certificate		5					
Physic	ian	1. Decedent's Nama (First, Middle, Last)	2. Date of Death Month Day Year 3. Time of Death	eath A A					
/Med		MARIETTA ROWE	December 8, 1999 /2:50	2 4/1					
Exam	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death 4c. County of Death						
		Williamsport Nursing Home	Williamsport Washington						
"Funera Directo		5. Social Security Numbar 220-16-1481 G. Sex 1 M 2 F 7. Age (In yrs. last birthday) To Months D Usual Residence of Decedent	Williamsport Washington Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Sept. 11,1921 Maryland	Foreign					
land w		10a. State 10b. County 10c. City, Town or Location	10d. Inside City	Limits					
the Maryland r 28a-f show	ō	Maryland Washington Clear Spring							
28a	9	10e. Street and Number 10f. Zip Co							
th with 23a or	Funerai Director	14108 St. Paul Road	21722 U.S.A.						
items 2	Jera	11. Marital Status 12. Was Decedant Ever in U.S. 13. Was Decedent	of Hispanic Origin? (Specify Yas or No- Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.						
2 6 8	by	1 ☐ Navar Married 2 ☐ Married 1 ☐ Yas 2 🕅 No	Cuban, Mexican, Puerto Rican, etc.) No Specify: Specify: White						
72 hours	To Be Completed	15. Decedent's Education 16a. Decedent's Usual O	ccupation 16b. Kind of Business/Industry						
within within then "re Med	ηpie	(Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work of life. DO NOT user	ccupation 16b. Kind of Business/Industry one during most of working stired)						
CV	Con	1 Accounting	g Clerk Gas Company						
nd all Hygin other	Be	17. Father's Name (First, Middle, Last)	18. Mother'a Name (First, Middle, Maiden Surname)						
arylan should be nd Mental marked o	0	Samuel Goodrick Frush Jr.	Nellie Matilda Sword						
Maryland d 2 should be file th and Mental Hy 7. Is marked othe treumatic event			reet and Number or Rurel Route Number, City or Town, State, Zip Code)						
ire, Maryland Stand 2 stand 2 should be filed if Health and Mental type item 27 is marked other treumatic event,			aul Road, Clear Spring, Maryland 2172	22					
DOFE ges 1 If the H to or oth		20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetary, crematory or other) 20b. Plece of Disposition (Neme of cemetary, crematory or other)	Date 20c. Location - City or Town, Stata						
Pee men men men men men men men men men m		4 □ Donation 5 □ Other (Specify) St. Paul'S Cen	3,	lanc					
Baltimore, M permit. Peges 1 and 2 Department of Health. Important: if item 27 it any injury or other tre ponce.		21. Signature of Funaral Service Licenses R. Roel Bull 40. Fast	ddrass of Facility Coffman Funeral Home, Inc. Antietam Street, Hagerstown, Md. 217	40					
1000		23a. Part1. Entar the disease, or complications that causad the death. Do not enter the mode of shock, or heart feilure. List only one cause on each line.	dying, such as cardiac or respiratory arrast, Approximate						
Physician	ш	Shock, of heart femule. List only one cause on each line.	Interval Betwe Onset and Dec	en ath					
/Medical		Immediate Cause (Final disaase or condition	2 11/00	60					
Examiner	Ш	disaase or condition resulting In death) e. ### Due to (or as a consequence of):	Q VOLER	0					
D %	Examiner	· aspiration	month	10					
and trans	cam	Sequantially list conditions, Due to (or as a consequence of):	7710-1	0					
. Box 68760, death certificate be executed e attending physician and of for use es the buriel-transit	9	nediate Cause (Final asses or condition ulting In death) e. PRELIMONIA Due to (or as a consequence of): MONTHS Due to (or as a consequence of): Due to (or as a consequence of): Caspiration Due to (or as a consequence of): Underlying use (Disease or injury initiated events Due to (or as a consequence of): Que to (or as a consequence of): Que to (or as a consequence of):							
68760, flicate be ex g physician as the bune	edical	that Initiated events resulting in death) Last Due to (or as a consequence of):	ase guer						
5 00	Me	d	41						
O. Box le death cer the attendin hed for use	ian	U.							
P.O. BOX that the death cel ed by the attendir detached for use	Physician/M	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause	e given in Pert I. 23b. Did tobacco use contribute to the cause of c	death?					
P.O.	Ph	Prossure Illeans	1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Un	known					
Les th	by	· resource activis							
I Records, P.O. The law requires that the steen signed by the page 2 should be detach	Completed	Pressure Ulcars Weight loss	24a. Was en autopsy performad? 24b. Were autopsy find available prior to						
Records,	nple	-002gm	completion of cause of death?	\$ 0					
	Cor		1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No						
of Vital Re Physician: The li this certificate he ral director, page	Be	25. Was case referred to medical exeminer?	26. Place of Death (Check only one)						
	P	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA	Other: 4 Nursing Home 5 Residence 6 Other (Specify)						
Sion o tending Ph leath. tor: After thi the funeral	00	27. Menner of Death 1 Naturel 5 □ Pending 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c.	Injury at 28d. Describe how injury occurred Work?						
Division or Attending after death. Director: After d in by the fune	catl	2 Accident investigation M 3 Suicide 6 Could not be 288 Place of taken Abburg for substitution in the could not be 1888 Place	1 Yes 2 No						
or At fler of freed in by	Certification:	28e. Place of Injury - At home, farm, street, factory, of building, etc. (Specify)	ice 28f. Location (Street and Number or Rural Route Number City or Town, State)	r,					
urs a urs a urs a liled i	I								
Hosp 24 ho Fune tely f	edical	29e. Certifier (Check only Check only 1 Certifying Physician: To the best of my knowledge, deeth occurred at the control of the best of examination and/or investigation, in respectively.	e time, dete and piece, end due to the cause(s) end manner as stated. ny opinion, deeth occurred at the time, date and place, end due to the cause(s)						
Division To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral completely filled in by the funeral preserves.	Med	end mariner stated.							
5 × 5 8	_	NO 1 1 1 50 1 10 1	ansa number 29d. Data signad (Month, Day, Year)						
1.		Cynotia Kuttner-Sondo, w D4	17451 December 8, 1999						
		Name end address of person who completed cause of death (Item 23a) (Type, Print)	17451 December 8,1999 a (Campus Rd., Hagerstown, M. 21742						
		YAHVA Kuttner-Jands, 1/110 Medica	al Campus Kd, Hagerstown, M.	D.					
Sta Regist		31. Dete filed (Month, Day, Year) 32. Registrar's Signature	21742						



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BALIIMORE, MARYLAND 21215-0020	24 hours after death. Page 6 may be retained by the hospital or attending physician.	is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should ith the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	the medical examiner must be notified at once.
DIVISION OF VITAL RECORDS, P.O. BOX 68/60	TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TA hours after death. Page 6 may be retained by the hospital or attending physician.	TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furbe filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.	IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

	1 - FOR STATE REGISTRAR	TE OF MARYLAND / DEPARTMENT (CERTIFICATE	OF HEALTH AND ME	NTAL HYGIENE REG. NO.					
	DECEDENT'S NAME (First, Middle, Last)	LILLIAN M. SEMLER		DATE OF DEATH DAY ECEMbe	C 15 199	3. TIME OF DEATH 8.45 PM			
	5. SEX 5. SEX 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) Sept. 6, 1904 Mai								
STOR	99. FACILITY NAME (If not institution, give street and in		OWN OR LOCATION OF DEATH		vne Somerset				
DIRECTOR	10a. STATE 10b. COUNTY Maryland Somer	LOCATION Sfield		10d. INSIDE CITY LIMITS? 1 YES 2 NO					
FUNERAL	100. STREET AND NUMBER 5030 Annemesse	x Road	101. ZIP CODE 21817		10g. CITIZEN OF WHAT COUNTRY?				
В	1 Never Married 2 Merried FOR	ICES7 1 YES 2 MNO It y	S DECENDENT OF HISPANIC Of Sec. specify Cuben, Mexican, Pu YES 2 NO Specify:	r No — 14. RACE Black, Specify	- American Indian, White, atc.				
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade completed Elementary/Secondary (0-12) Grade 8 College	16a. DECEDENT'S USUAL OCCI (Give kind of work done duri life. Do NOT use retired.) Saleslady	JPATION ing most of working	16b. KIND OF BUSIN	ent Stor	`e			
BE CON	17. FATHER'S NAME (First, Middle, Last) William Miner		18. MOTHER'S NAME (I	First, Middle, Malden Su Miner	imame)				
10	190. INFORMANT'S NAME (Type/Print) Lois M. Chew (daught	er) 19b. Mailing Address (S	treet and Number or Rural Route Nessex Road -	Number, City or Town, Crisfiel	State, Zip Code) d, MD 2	1817			
	20e METHOD OF DISPOSITION 1 & Burlel 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	State 20b. PLACE AND DATE OF DISPOSITION COMPANY OF THE PROPERTY OF OTHER PLACE.			TION — City or Tow Brentwoo				
	21. SIGNATURE OF FINERAL SERVICE LICENSEE ROBert H. Bradsha	Br	me and address of facility adshaw & Son 06 W. Main St	s Funeral	Home	21817			
	23. PART I. Enter the diseases, or complice shock, or heart fellure. List only IMMEDIATE CAUSE (Final	tions that caused the death. Do not enter the process on each line.	a moda of dying, auch as	cardiac or respire	tory arrest,	Approximata Interval Between Onset and Death			
	Due to (or as a consequence of): A 12 H E I M ERS DEMENTA Onset and Death I W K. A 12 H E I M ERS DEMENTA 3 475.								
NOI	Sequentially list conditions, if any, leading to immediate A 12 H E I M ERS DEM ENTIA 3 475.								
CERTIFICATION	cause. Enter UNDERLYING CAUSE (Oisease or injury that initiated events resulting in death) LAST								
AL	PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I, 24s. WAS AN AUTOPSY PERFORMED? AMAILBLE PRIOR TO								
PHYSICIAN: MEDIC				1 - YES 2	I NO	COMPLETION OF CAUSE DF DEATH?			
CIAN	25. WAS CASE REFERRED TO MEDICAL EXAMINER?	TO CAUSE OF DEATH YES NO		<u> </u>					
IYSI	1 YES 2 NO 1 Inpi	itlent 2 ER/Outpatient 3 DOA Nursing	Home 5 Residence 8						
ВУ Р	Netural 5 Pending 2 Accident Investigation	(Month, Day, Year) INJURY M	WORK?	I. DESCRIBE HOW INJI					
ETED	4 Homicide determined	PLACE OF INJURY — At home, ferm, atreet, factory, building, etc. (Specify)	office 28t.	LOCATION (Street end City or Town, State)	Number or Rural Ro	ute Number,			
COMPLETED		he best of my knowledge, death occurred at the time, bests of examination end/or investigation, in my opini				end menner ea stated.			
TO BE (LECTOR	29c. LICENSE NUMBER	2	29d. DATE SIGNED (Month, Day, Year)				
	DR. USHA NATESANI	M.D 12208 Brithing	ham have	, Rin Cass	Anne 1	10 4853.			
	31. DATE FILED (Month, Day, Year) 32. DEC 2 0 1999	REGISTRAN'S SIGNATURE	1.						
		1. poor	2			OHMH-18 Rev 1/89			

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2700 **Physician** Thelma Catherine Shaffer December 1999 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 13831 Greenfield Avenue Maugansville Washington County If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Feb. 24, 1 If Under 1 Year 5. Social Security Number Birthplace (State or Foraign Country). 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2 XF 65 Yrs. Maryland 216-30-1777 1934 Director Usual Residence of Decedent with the Meryland 10a Stata 10b. County 10c. City, Town or Location 10d. fnslda City Limits Itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumetic event, the Medical Examinar must be notified at Maryland Washington Co. 1 ☐ Yas 2 No Maugansville Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 13831 Greenfield Avenue 21767 U.S.A.

14. Raca - Amarican Indian, Funeral death 12. Was Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should be filled within 72 hours after and Mental Hygiens. Is marked other than "natural" or item. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Private Residence 12 0 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frederick Luther Walter, Sr. Rachel Elizabeth Schmidt 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 sh Department of Health and Important: If Itam 27 is m any injury or other traum once. Wade C. Shaffer/Husband P.O. Box 194, Maugansville, Maryland 21767 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 St Burial 2 ☐ Cremation 3 ☐ Removat from State Rest Haven Cemetery Dec.21 4 ☐ Donetion 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Douglas A. Fiery Funeral Home 1331 Eastern Blvd.N., Hagerstown, Maryland 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete tnterval Between Onset and Death Physician Immediate Ceuse (Finat disease or condition resulting In death) /Medical bacterial endocarditis Examiner Due to (or as e consequence of) Examiner congestive heart failure lician and buriel-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): certificate be exec Box 68760. ettending physician valvular heart disease Physician/Medicai the Dua to (or as a consequence of) SB end stage renal disease or peritoneal dialysis 950 23b. Did tobacco use contribute to the cause of death? P.0. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. the à 3 Probably 4 Unknown 1 Tyes 2₺ No Division of Vital Records, þ 8 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed Deen completion of cause of death? Sec page 2 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) funeral 28c. fnjury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 5 Pending 1 Naturel 1 Yes 2 No death. investigation 2 Accident ofter death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Sulcida 28e. Placa of tnjury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 ☐ Homicide 24 hours Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the bests of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 the 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifian 29c. License number 0 BY6111823 December 20, 1999 MD 30. Name and eddress of person who completed cause of death (ttem 23a) (Type, Print) Yan Ping Yu, MD 12931 Oak Hill Avenue, Hagerstown, Maryland 21742 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State eper DEC 21

DHMH 16 Rev 6/95

Registrar

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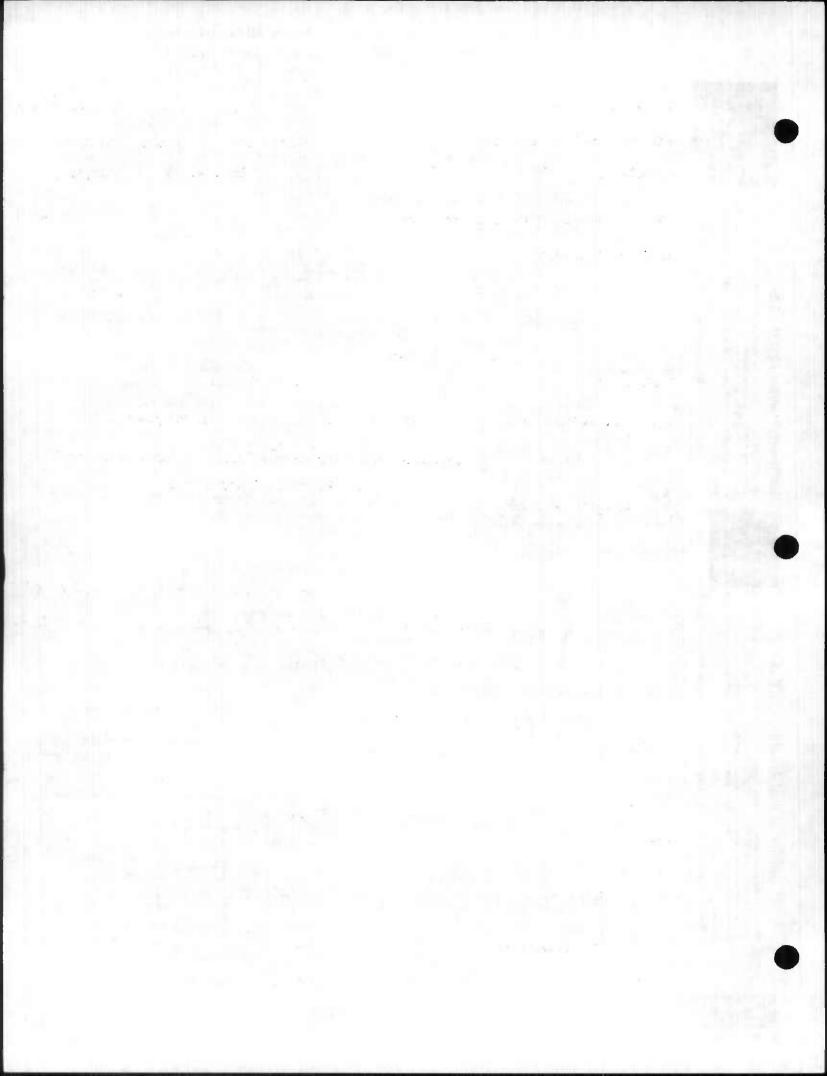
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 **Physician** Irvin Samuel Shank 16 12 - /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Mennonite Fellowship Home Hagerstown Washington County If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Feb. 4, 15 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 11K] M 2□ F Months Days Hours 83 Yrs. 214-09-3594 Maryland Director Usuel Residence of Decedent with the Marylenc 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show Injury or other traumatic event, the Macical Examinal must be notified at 1 Yes 2X No MD Director Washington Co. Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12349 Huyett Lane 21740 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mentel Hygiena. Important: If Item 27 Is marked other than "natural", or Items 23. Funerai 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify: White altimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Interior Owner 8 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Emma Martin Daniel Shank 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) 14319 Marsh Pike, Hagerstown, Maryland 21742 Richard E. Shank/Son 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Paradise Mennonite Church Dec.20 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Douglas A. Fiery Funeral Home 21. Signature of Euneral Service Licensee 23. Part1. Enter the essease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear bailure. List only one cause on each line. 21742 1331 Eastern Blvd.North, Hagerstown, MD Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Puramonia Examiner Examiner Vascular ician and burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last but to for as a gonsequent of its swallow heroscless Vas cular Division of Vital Records, P.O. Box 68760, Physician/Medicai the Due to (or as a consequence of): 98 Wellitas esn 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 20No Hypothyroidesm 3 Probably 4 Unknown signed t þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed vas ular diseau certificate has 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Wes case referred to medical examiner?

1 Yes 28 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Aftar this funeral 28b. Time of 28d. Describe how Injury occurred 27. Menner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Dev Year) 5 Pending investigation Natural aftar death. Director: Aft 1 Yes 2 🗆 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) and manner es steted.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier E VVI mun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary E Money m D 35 y Mich MILL STREET, HAGERSTOWN, MD21740 Mary E Money MD 31. Date filed (Month, Dey, Yeer) DEC 1 7 1999 32. Registrar's Signature State Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 1999 15 CLAYTON HARRY STARLIPER DEC 2215 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner HAGERSTOWN
If Under 24 Hrs. 8. Date of WASHINGTON COUNTY HOSPITAL WASHINGTON 5. Social Security Number 7. Age (In yrs. last birthday) 79 Yrs. If Under 1 Year 6. Sex 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months 15€M 2□F Deys Hours Min. 181-07-4832 Director Upton, PA Usual Residenca of Deceden the Menyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Itam 27 is marked other than "natural", or Itams 23a or 28a-4 show other traumatic event, the Medical Examiner must be notified at 1 Nes 2 No Md Washington Hagerstown Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 1617 Dual Highway 21740 USA Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Depertment of Health end Mental Hyglene. Important: If item 27 is marked other than "natural; or Items 23, any Injury or other fraumatic event, as Montal Engine mannament. 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. Bleck, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 If Yes, Give Year or Dates: 1 Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Maintenance Trailer Park 18. Mother's Name (First, Middla, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Spirdie W. Starliper Mary Blanche Gearhart 19b. Mailing Addrass (Street and Number or Rurat Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Daugh Nancy D. Coulter-Brantner 16841 Shinham Rd Hagerstown MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20c. Location - City or Town, State Antrim Township Franklin Co, PA 1 Burlal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Spacify) Browns Mill Cemetery Dec 20 22. Name and Address of Facility 21. Sign (the of Funaral Sarvice Licension Miller-Grove Funeral Home ames owerso 521 S Washington ST Greencastle James A. Bowersox 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) 12801/210 Examiner Dua to (or as a consequence of) Examiner sician end burial-transit umonia certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. ettending physician Physician/Medical the Due to (or as a consequence of): 98 USB USB signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy performed? peen completion of cause of daath? hes 1 Yes 2 KNo 1 ☐ Yes 2 ☐ No Division of Vital i or Attanding Physician: after death. Director: After this certific funeral director. 25. Was cese refarred to medicel examiner? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospital 24 hours g 24 hours a 29a. Certifier (Check only one) 1 Cartifying Physician: To the best of my knowledge, death occurred at the tima, date and place, and dua to tha causa(s) and manner as stated. Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and the of partifier 29d. Date signed (Month, Day, Year) 29c. License number D47101 December 15, 1999

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31. Date filed (Month, Day, Year)

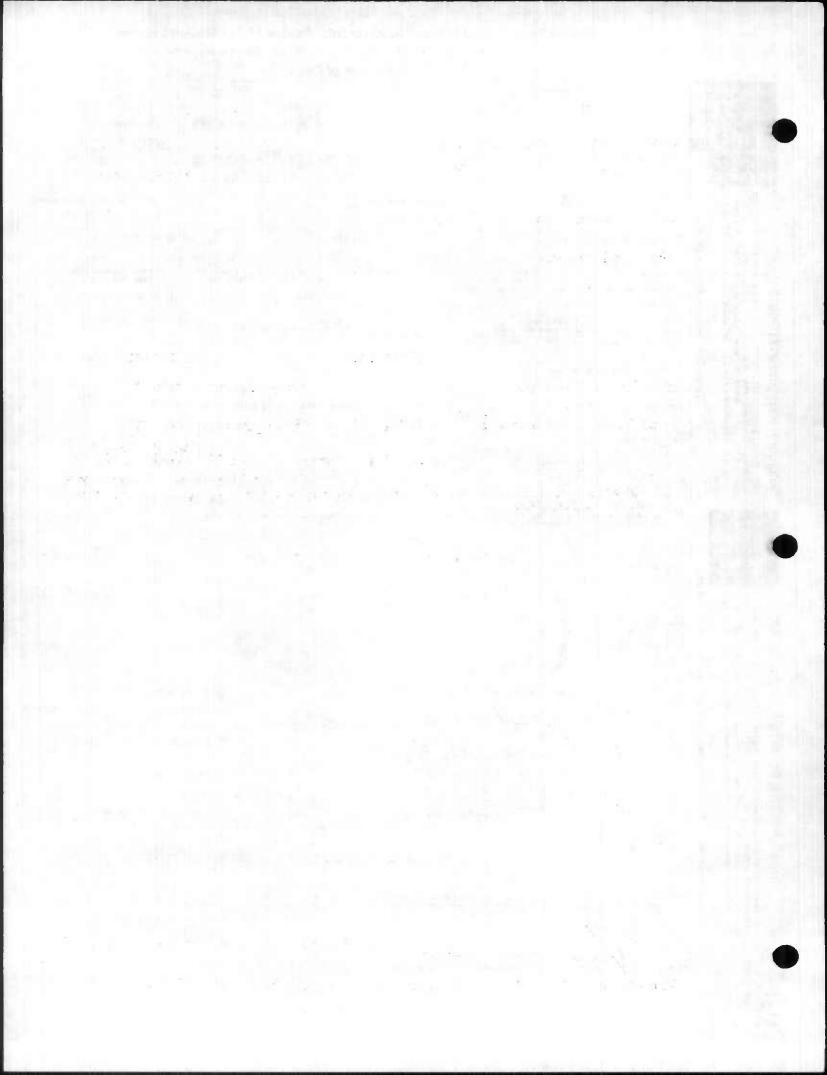
30. Nama and dass of person who completed cause of death (flam 23a) (Type, Print)

1999

324 E Antietam ST

32. Registraf's Signature

Hagerstown, MD



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Yaa **Physician** 6:29 PM December 16, 1999 Gerald George Sowash /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death Examiner Abingdon If Undar 24 Hrs. 353 Butterfield Drive 6. Sax Harford Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) If Undar 1 Yaa 8. Data of Birth (Month, Day, Year) **Funeral** Hours Days 152 M 2□ F Months Director 52 223-62-2729 Sept. 23, 1947 Maryland Usual Rasidence of Dacedani the Marylend 10a Stata 10c. City. Town or Location 10d. insida City Limits 10b. County 28a-f show 7 is marked other than "naturel", or frems 23a or 23a-f show treumstic event, the Mozical Examiner must be notified at 1 Yas 2 No Director Maryland Harford Abingdon 10e. Street and Number 10f, Zip Coda 10g. Citizan of What Country? with 353 Butterfield Drive 21009 TISA Funeral deeth 12. Was Dacedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 13. Was Decedant of Hispanic Orlgin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, atc. filed within 72 hours efter 1 Navar Married 35 Married 3altimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White þ 3 ☐ Widowad 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada complated) Tractor Peges 1 and 2 should be filed within tent of Health end Mental Hygiene. nt: If Nem 27 is marked other than " Elemantary/Secondary (0-12) College (1-4or 5+) Sales & Service Technical Service Manager 12 18. Mother's Name (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Be Harold Lewis Sowash Mary Helena Neff 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code) Patricia A. Sowash / Wife 353 Butterfield Dr., Abingdon, Maryland 21009 other 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 00 Department of Important: If any injury or 12-20-99Towson, Maryland Hilltop Service Corp. 22. Nama and Addrass of Facility 21. Signatura of Funaral Sarvice Licensea McComas Funeral Home, P.A. /we 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enfer the disease, or complications that causad the death. Do not enter the moda of dying, such as cerdiac or raspiratory arrast, shock, or heart failura. List only one causa on each line. Approximata Intarvai Batween Onset and Death **Physician** /Medical Immediate Cause (Final CANCER disaasa or condition rasulting in death) Examiner Examiner MPHYSEMA certificate be executed the buriel-transit Sequentially list conditions, if any, laading to immadiate ceuse. Enter Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last and physician HNEMIA Physician/Medical Dua to (or as a consaguance of) 95 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? O 1 Yes 2 No 3 Probably 4 Unknown Records. à 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performad? peen hes 1 Yas 2 No 1 TVas 2 No certificate Division of Vital 25. Was cese refarred to medice Be 26. Placa of Daath (Check only one) axaminar? Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No 2 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this funeral Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 27. Manner of Death 28b. Tima of Certification: Injury at Work? After 5 Pending invastigation 1 Naturai Injury 1 ☐ Yas 2 ☐ No ne Hospital or Attendin n 24 hours efter death. Ne Funeral Director: A death. 2 Accidant 6 Could not be datarmined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) 4 T Homicide 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Cartifiar To the Hosp within 24 hou To the Fune completely fil Medical 29d. Date signed (Month, Day, Year) 29c. Licensa number 29b. Signatura and titla of certifian MM) DECEMBER 17, 1999 CR and address of person who completed cause of death (item 23a) (Type, Print) TAHMOOD M.D. 4-C NORTH AVENUE SUITE 424 BEL AIR MARYLAND

32. Registrar's Signatura

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DHMH 16 Rev 6/95

State

Registrar

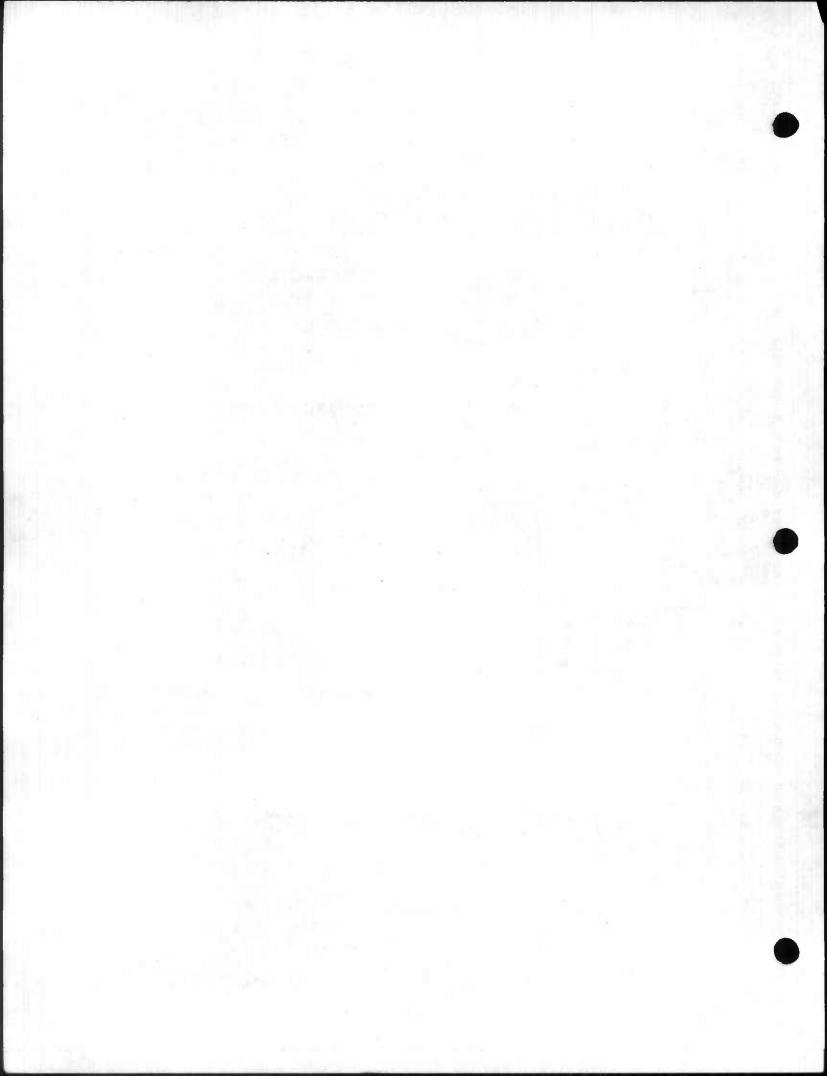
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Deta of Deeth Month **Physician** Harold. Arthur Twentey 1640 1999 December 19 /Medical 4a Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Dey, Year) Th 16,1914 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yaar If Undar 24 Hrs. 9. Birthplece (State or Foreign **Funeral** 1⊠M 2□ F Months Deys Hours Country) Maryland 85 214-10-1273 Director Usual Residence of Decedent the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or Nems 23s or 28s-f show adical Examiner must be notified at Maryland Washington Hagerstown 1 Yes 2CXNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 11317 Manse Road 21740 U.S.A. Funeral 12. Wes Decedent Evar in U.S. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien. 11 Medital Status Bleck, Whita, etc. Pages 1 and 2 should be filed within 72 hours after of health and Mental hygiena.
Int: if fem 27 ie marked other than 'natural', or Nei ny or other transmire in yor other transmire. 1 TXYes 2 □ No If Yes, Give W.W.II Year or Detes: 1 ☐ Nevar Married 2 ☑ Married Baltimore, Maryland 21215-0020 white 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced al Hygiens.
d other than "natural
avent, the Medical F Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) 0-12 College (1-4or 5+) state fuel investigator state govt. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) - Sadie Ellen George Leonard Twentey 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 11317 Manse Road, Hagerstown, Maryland Mr. Eileen A. Twentey / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, Stete Department of Important: If It any injury or o Dec. 15,1999 Sharpsburg, Maryland 1 Burial 2 □ Cremetion 3 □ Removel from State amples Manor Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onsat and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examine sician and burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) physician s the burial Box 68760, Dua to (or as a consequence of) 98 for use a signed by the a Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 | Yee 2 No 3 | Probably 4 | Unknown Records. þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 a 1 Yes 2 TNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 1 Impatient 3□ DOA 2 ER/Outpatient this 28a. Dete of Injury (Month, Day Year) unerai 27. Manner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred After or Attending 1 DiNeturel 5 Pending investigation 1 Yes 2 No r death. 4 hours after death uneral Director: / 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner stated. 29e. Certifie (Check only one) And Airle of 29b. Signature 29c, License number 29d. Data signed (Month, Day, Year) 0 30. Name and addre ss of pe son who completed cause of death (Item 23a) Type Via 32. Registrar's Signatura 31. Dete filed (Month, Day, Year) State DEC 3 Registrar

wentey, Harold



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

			Ce	rtificate of	Death		Reg. No.	410	26			
	1. Decedent's Name (First, Middle, I	Last)				2. Dete of De Month	eth Day	3. Time	of Deeth			
Physician	Mabel J	. Thornton				DECEM	- 0' -	1999 8	" IPM			
/Medical Examiner	4e Fecility Name (If not institution, g				4b. City, Town, or							
Examine,	Mariner He	alth- Bel A	Air		Bel Air		Har	ford				
Funeral	Sociel Security Number 6.	Sex 7. Age (In	yrs. last birthday)	If Under 1 Yee				9. Birthplace (State Country)	e or Foreign			
Director	213-40-1413 Usual Residence of Decedent	1 M X	91 Yrs.	MORRIS Day:	S Hours Mil	1/19/		Delta, PA				
land wo	10a. State 10b. County	100	c. City, Town or Lo	ocation				10d. inside	City Limits			
h the Maryland r 28a-f ahow Inciffed at frector	MD Harfo	rd S	Street					1 🗆 Yo	es all No			
the profit	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?				
O iter death with the Mai r terms 23s or 28s-1s other must be motified funeral Director	3948 Old Rock	s Road			21154		USA					
items per dea	11. Maritei Stetus	12. Wes Decedent Ever Armed Forces?	in U,S. 13.	Wes Decedent of If Yes, specify Cu	Hispenic Origin? (ben, Mexican, Pue	Specify Yes or No rto Ricen, etc.)	- 14. Rac Blac	e - American Indian, ck, White, etc.				
urs e	1 ☐ Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes ZCMo If Yes, Give Yeer or Dates:		1 □ Yes 2○ €	Specify:		Specity: White					
21215-0020 and within 72 hours at rependence. The Wed call Exercity or the Wed call Exercity Completed by F	15. Decedent's (Specify only highest g	rede completed)	16a. Dece (Give	dent's Usuel Occi kind of work don DO NOT use retir	upetion e during most of wo	orking	16b. Kind of Bu	usiness/Industry				
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2 should be fled within and Mertal Hygiene. Is married other than numetic event, the M	19a. Informent's Name/Reletionship		19b. Maili	ng Address (Stree	et and Number or F			State. Zip Code)				
	Brenda T. Hinc				ocks Rd							
re, IV	20a. Method of Disposition		Ob. Plece of Dispo	osition (Neme of	(aca)	Date	20c. Location -	City or Town, State	2			
Destumore, n parmit. Pages 1 and Department of Health important; if Item 27 any Injury or other to ance.	A Burial 2 ☐ Cremation 3 4 ☐ Donetion 5 ☐ Other (Spec		Highlan	d Cemet		2/19/99	Stree	t, MD				
Semit. Pa Separtmen myortant: any injury ance.	21. Signature of Funeral Service Lic		2 1 2	2. Name and Add	ress of Fecility							
Departit. Depart	Harkins F.h.Inc., Delta, PA 17314											
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/Medical	mmediate Cause (Final disease or condition END & Metrial CA-CAR											
Examiner	resulting in death)											
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within 2 To the comple	29b. Signeture and tittle of certifier	•		29c. Lice	nse number		29d. Date signe	ed (Month, Dey, Year	7)			
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3	30. Name and address of person wh	o completed cause of death	(Item 23a) (Type	Print)	2100							
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State	31. Dete filed (Month, Dey, Year)	32 Registrar's S	Signeture	1								
Registrar	DEC 1 7 19	199 Spices	D.	Spark	2							

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** 1901 SAMUEL M. WEBB, JR. 12 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 6. Sex 1 2 M 2 □ F If Under 24 Hrs. Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months 226-20-1747 Virginia January 10, 1923 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Somerset Westover 1 ☐ Yes 2 No Funeral Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 8686 Lake Somerset Lane 21871 must b U.S.A. 12. Was Decedent Ever in U,S.
Amed Forces?
1.2 Yes 2 No. 1944. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 8 1 Yes 2 No Specify: Specify: White b 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Farmer Farming Grade 6 Pages 1 and 2 should be filed w timent of Health and Mental Hygier tant: if Item 27 is marked other if lury or other traumatic event, Iby Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Samuel Magruder Webb Trudie Ann Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8686 Lake Somerset Lane - Westover, MD Linda K. Webb (Wife) 21871 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal Irom State Fastern Shore Veterans Cemetery 12/20/99 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europel Service Lie 22. Name and Address of Facility Bradshaw & Sons Funeral Home Robert M. Bleckfla 306 W. Main St. - Crisfield, MD 21817 Robert H. Bradshaw, Jr. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician ACUTE PANCREATITIS Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificata be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Box 68760, Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Onknown Division of Vital Records. Completed by 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 1 Yes 2□No 1 PYes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attending 1 Natural
2 Accident 5 Pending investigation To the Hospital or Attending within 24 hours after death.

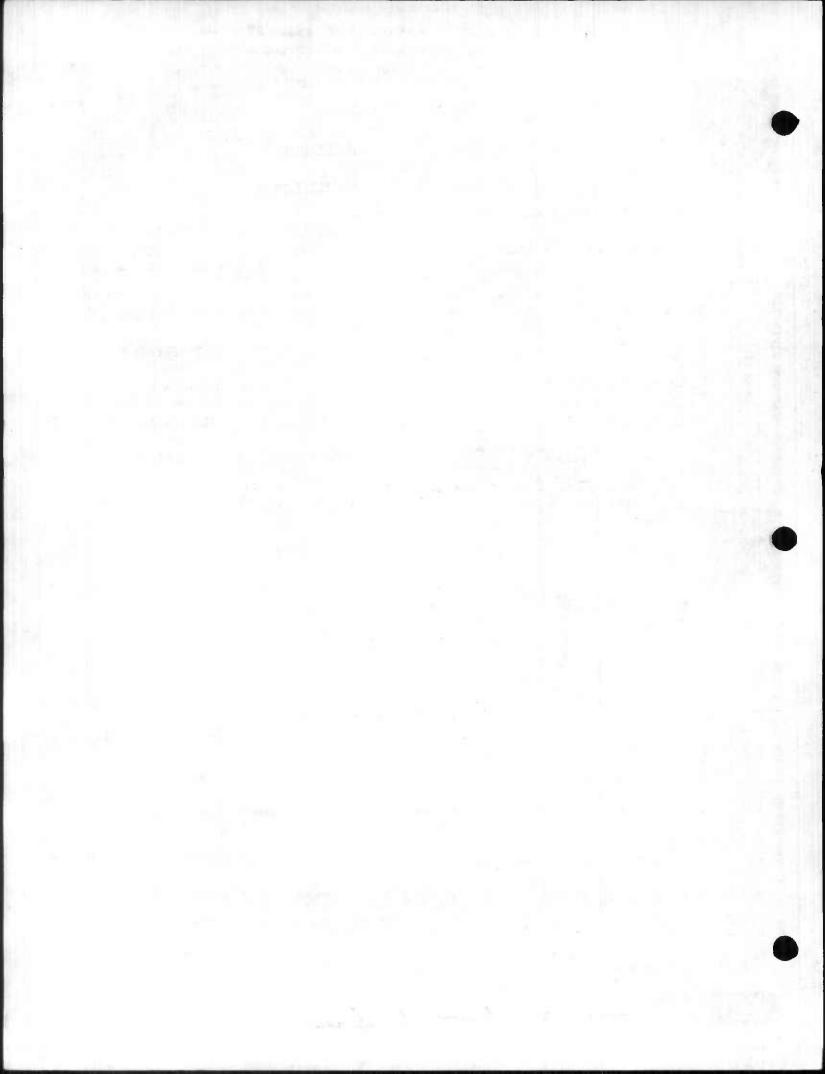
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2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the (Check only ner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cer DECENSEN 1711855 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 RIVENSIOL-RIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Ray 6/95

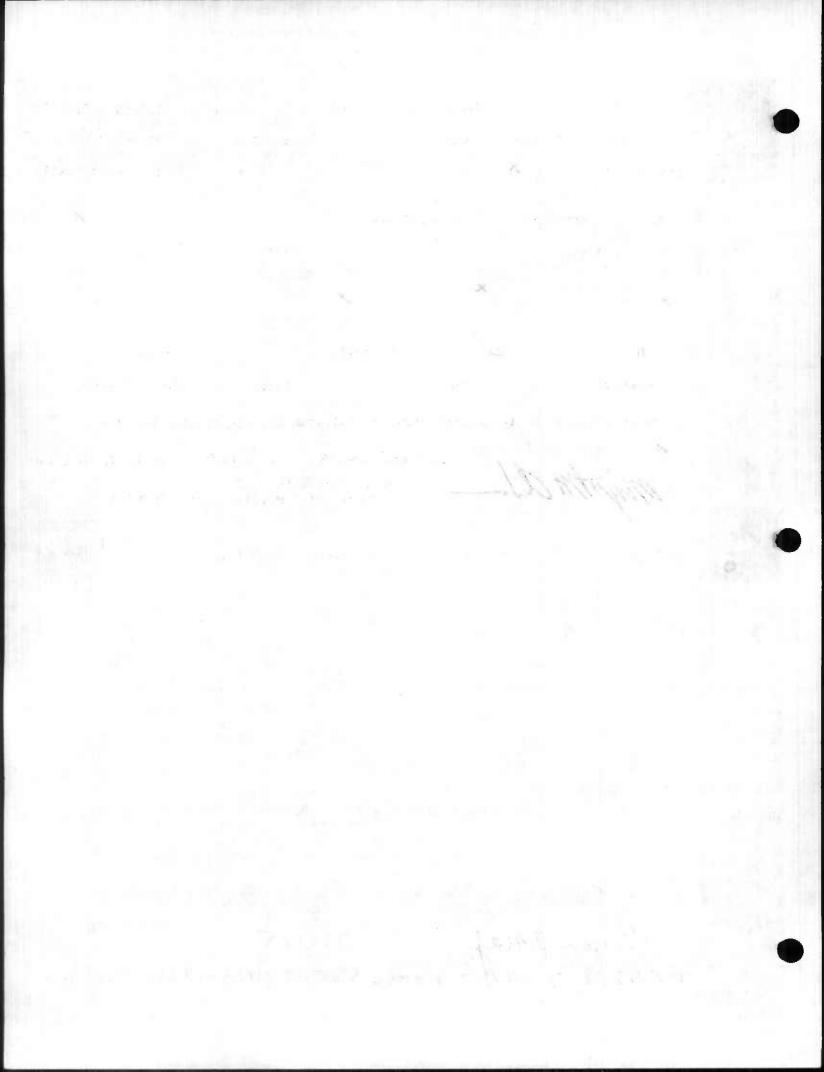
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** Month MATTIE LUVINA WELLS DECEMBER 18,1999 12:00AM /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner CHESAPEAKE WOODS CENTER-GENESIS ELDERCARE CAMBRIDGE DORCHESTER 5. Social Security Number 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) SEPT. 27, 1905 Birthplece (State or Foreign Country) **Funeral** 1□M 2ĬF Deys Hours Director 218-07-0466 94 MARYLAND Usuel Residence of Decedent the Maryland 10e. Sfete 10b. County 10c. City, Town or Location 10d. Inside City Limits 25a-f show must be notified at 1X Yes 2 □ No Director MARYLAND DORCHESTER HURLOCK 10e. Street end Number 10f. Zip Code 10g. Citizen of Whef Country? 8 Harris 23a 212 CHARLES STREET 21643 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 11. Meritel Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 b 1 Yes 2 No Specify: by Specify: 3 Nidowed 4 Divorcad "natural", WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grede completed) Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 ahould be filled w Department of Health and Mental Hygien, Important: If Nem 27 is marked other tha any Injury or other traumeric -LABORATORY FOOD ANALYST MANUFACTURING 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) MEDFORD STOKER MAGGIE SAUNDERS 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) JOANN S. WYATT/DAUGHTER P. O. BOX 219, HURLOCK, MD 21643 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 □ Cremetion 3 ☐Removel from Sfate UNITY WASHINGTON CEM. 12/20 4 Donetion 3 ☐ Other (Specify HURLOCK, MARYLAND 21. Signature of Funeral Service I 22. Name end Address of Fecility ZELLER FUNERAL HOME, P. O. BOX 207 encer 106 MAIN STREET, EAST NEW MARKET, MD 21631 rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth Physician /Medical Immediate Cause (Final 1 min disease or condition resulting in death) Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest pug Due to (or es e consequence of): P.O. Box 68760, Physician/Medical 8 Due to (or es e consequence of) Ħ esn Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? ate has been signed by page 2 should be detac 1 Yes 2 No. 3 Probably 4 Unknown comen FIN Records, Completed by 24e. Wes en eutopsy performed? 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? certificate 1 ☐ Yes 2 RNo Division of Vital Hospital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: 4 Nursting Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred After 1 Maturel 2 ☐ Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es steted.

| Medical Examinar: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated. 29e. Certifier Medicai 2 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 30 Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) J. FADDEN, 302 COLLINS AVENUE, HURLOCK, MARYLAND 21643 31. Dete filed (MDF Cay, 200) 1999 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Madge WETZEC December 14, 1999 1:25 a.m. /Medical 4a. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Colton Villa Nursing Home LUNC Hagerstown Washington If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) Birthplaca (Stete or Foreign Country) Funeral Months Days 83 216-38-2218 Director April 15,191a Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location items 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1X Yes 2 No Maryland Washington Hagerstown 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 Willard Street USA 21740 death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11. Menital Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter Department of Healith and Mental thygiene. Important: If flem 27 is marked other than "natural", or its any injury or other traumatic event, the Mental Engine. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: white þ 3 Widowed 4 □ Divorced Year or Dates: Be Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Meiden Surname) William M. Williams Violet H. Godlove 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Paul W. Wetzel - son 10616 Bower Ave., Williamsport, Md. 21795 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery 12-17-99 4 Donation 5 Other (Specify) Hagerstown, Maryland 22. Name end Address of Facility MINNICH FUNERAL HOME 21. Signeture of Furnal Service Licenses coall 415 E. Wilson Blvd., Hagerstown, Md. 21740 Minne 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervei Between Onset end Deeth Physician DUSIE ASI Immediate Cause (Final disease or condition resulting in deeth) /Medical ATHEROSCLEROTIC CARPIO VASCULAR MINS **Examiner** DBMEN71A Physician/Medical Examiner The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or es a consequenca of): and the burial-tran Box 68760, LUNG mass physician Due to (or as e consequence of) 98 for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 23b. Did tobecco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Was en eutopsy 1 Yes 2 1 No 1 ☐ Yes 20 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes case referred to medicel examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Apply Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Deeth 1 Alatural 2 Accident 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, end due to the ceuse(s) and manner as stated.

| Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29s. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

rson with completed cause of deeth (Item 23a) (Type, Print)

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32. Registra/s Signature

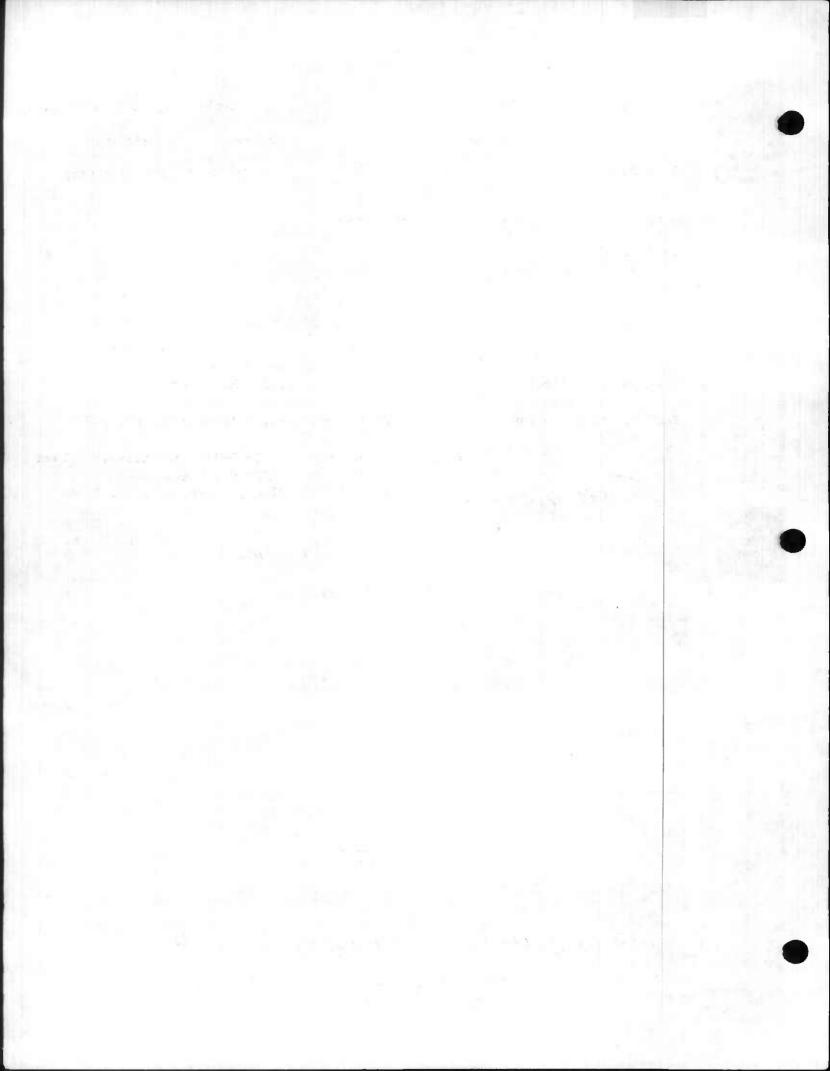
SHAFI 368 MILL ST HAUTERS TOWN 19D21740.

State Registrar

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MANZAR.

31. Date filed (Month, Day, Year)
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Marshall 510 Am 12 10 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street end number) 4c. County of Death of Medical System -niversity Raltimore City of Marylan If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Montha Days 10 M 20 F 220-34-082 6/1 Maryland **Usuel Residence of Decedent** 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits 1KIYes 2□No Maryland Washington Fairplay 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 8019 Sharpsburg Pike 21733 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, Whita, etc. 12. Wes Decedent Ever in U,S. Armed Forces? ☐ Yes 2 No f Yas, Give 1 Never Married 2K Merried 1 ☐ Yes 2 ☑ No Specify: Specifiwhite 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest greda completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) truck driver trucking 11 0 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marshall W. Winters, Sr. Minnie Viola Bishop 19e. informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon M. Winters - wife 8019 Sharpsburg Pike, Fairplay, Md. 21733 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 1⊠ Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Lawn Mem. Park 12-14-99 Hagerstown, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23e. PartT. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediete Ceuse (Finel disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or es e consequence of):

Physician /Medical Examiner

0 = 0

Department of Important: If any injury or pace.

Physician

/Medical

Examiner

Funeral

Director

show

must be notified at

Nems

Peges 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
int: If Item 27 is marked other than "natural", or he

Saltimore, Maryland 21215-0020

Funeral Director

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Be Completed

with the Maryland

Examiner Physician/Medical the ate has been signed by the attending p page 2 should be detached for use as Completed by Be Medical Certification: To To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

The lew requires that the deeth certificate be axecuted

or Attending Physician:

After this

Division of Vital Records, P.O. Box 68760.

Pert li. Other significant conditiona co	entributing to death but not re	sulting in the underlying	g cause given in Pert I.		Contact of the Contac	ntribute to the cause of deeth?		
				_ 7	24a. Was an autopsy performed?	24b. Were autopsy findings aveilable prior to completion of cause of death? 1 Yes 2 No		
25. Was case referred to medical			26. Place o	Death (Check only one)			
examiner? 1 Yes 2 No	Hospitel: 1 Impatient 2	☐ ER/Outpatient 3☐	DOA Other: 4 Nurs	ing Home	5 ☐ Residence 6 ☐ Ott	ner (Specify)		
27. Menner of Deeth 1	28a. Dete of injury (Month, Dey Year)	28b. Time of fnjury	28c. fnjury at Work?		8d. Describe how injury occurred			
3 Suicide 6 Could not be 4 Homicide determined	28e. Pieca of Injury - At I building, etc. (Special		281	28f. Location (Street and Number or Rural Route Number, City or Town, State)				

State Registrar 29b. Signature and talle of certifier

31. Date filed (Month, Dey, Year)

3 1999

Stephen Jummers, mo 32, Registrar's Signeture

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

DMMS, 22 S. Greene St Baltinone MD 21201.

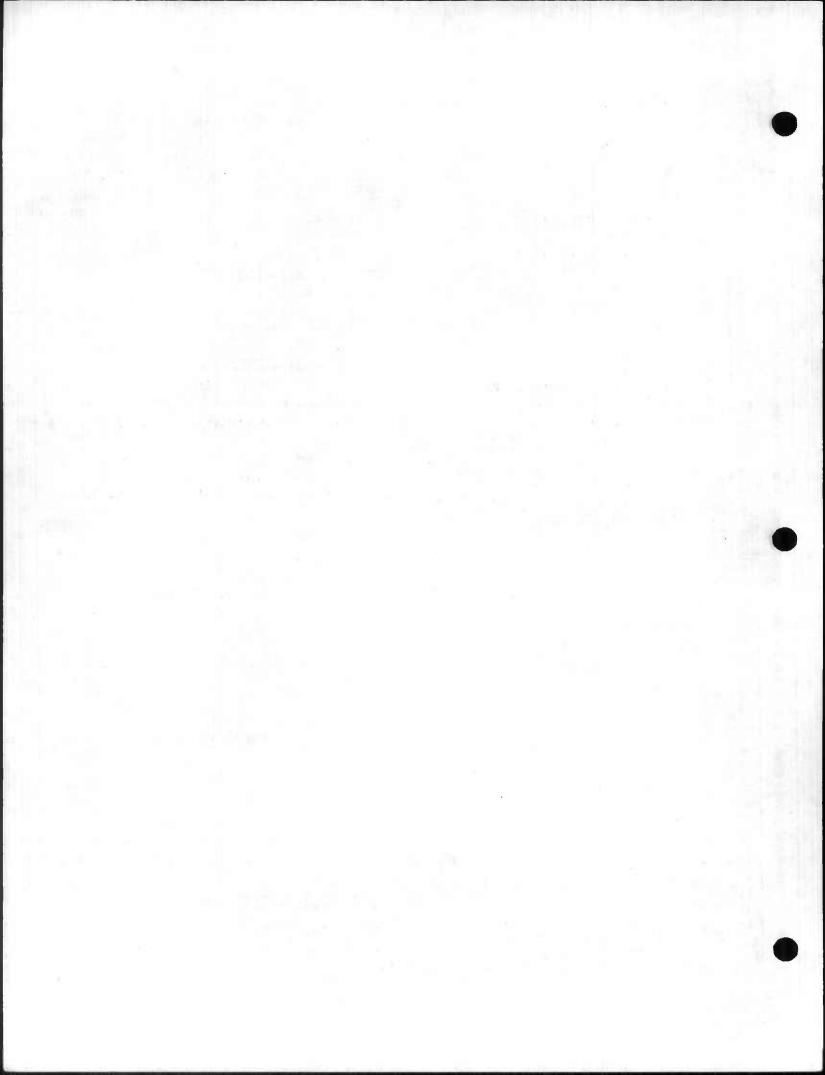
29c. License number

P13412

29d. Date signed (Month, Day, Year)

12/10/99

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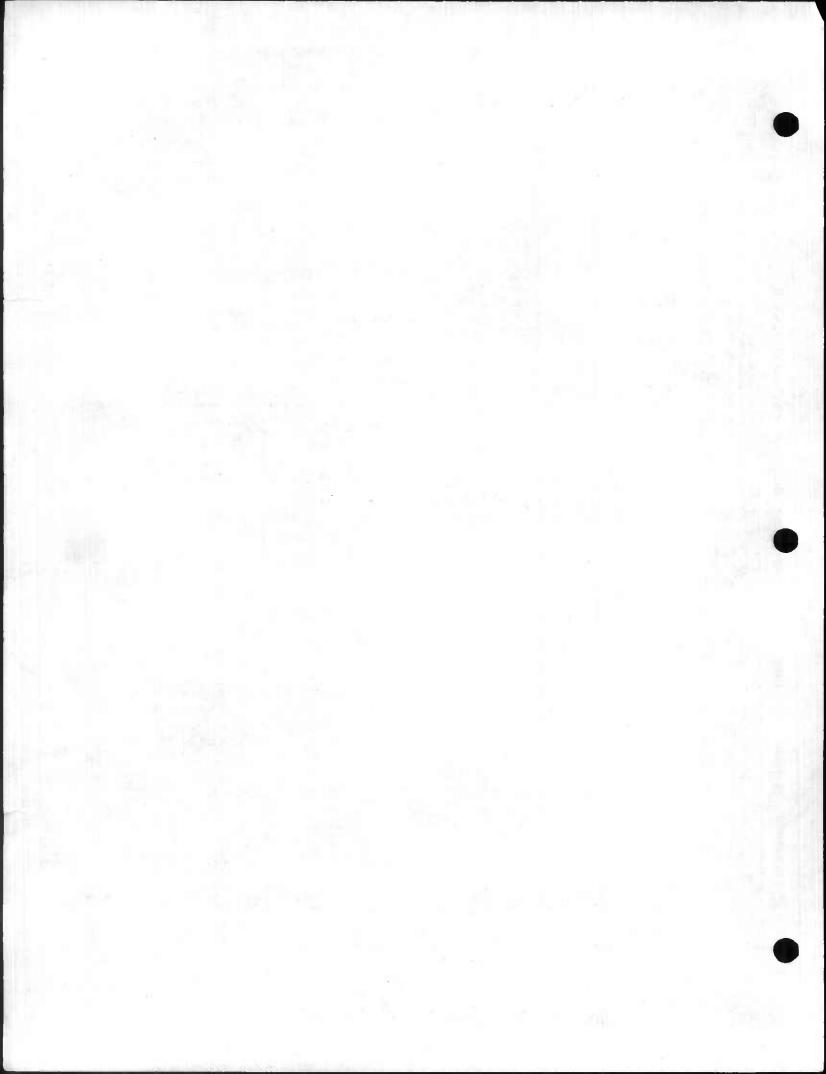


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Q Q 41598 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death December 24, 1999 **Physician** Charles William . Allen 3:05 pm /Medical 4a Facility Name (Il not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Frederick Frederick Frederick Memorial Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1∭M 2□F Months Director 220-38-1176 Aug 16, NC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or itema 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 355 Montuview Lane 21701 USA Funeral deeth 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Statue Black, White, etc. Pages 1 and 2 should be filled within 72 hours after ment of Health and Mertel Hyglene.
unt: if item 27 is marked other than natural; or itea way or other traumate avent, its Mexical is not in my or other traumate avent, its Mexical is not in the mexical in the mexical is not in the mexical in the mexical is not in the mexical in the mexic 1 ☐ Yes 2 ☑ No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: white Baitimore, Maryland 21215-0020 Specify. þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 0 floorsander restoration 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Manuel Charles Allen Magnolia Tanner 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila Wactor/grandaughter 1990 Shookstown Rd Frederick, Md 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: if it eny injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 □ Donation 5 X Other (Specify) in state Wade, Director 22State Affactory Board 655 W. BaltimoreStreet 21. Signeture of Funeral Service Licensee RODALO 5. Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, hock, or heart feiture. List only one cause on each line. Approximele Interval Between Onset end Death **Physician** /Medical tmmediate Cause (Final disease or condition resulting in death) Congestive hear Examiner Due to (or as a consequence of): Physician/Medical Examiner Cormary sician and burial-transit ar The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of) Box 68760, physician s the buria Due to (or as e consequence of): 980 Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. Records, P.O. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown DN Lumma þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed page 2 s 2 10 No 1 ☐ Yes 2 ☐ No 1 Tyes Division of Vital or Attending Physician: 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 FMOutpatient 3 DOA this funeral 27. Menner of Death 28d. Describe how injury occurred Certification: 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Netural 5 Pending investigation within 24 hours after death. To the Funeral Director: At 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of tnjury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier completely (Check only one) To the ! 29b. Signature and title of certifie 29c. License numbe 29d. Dete signed (Month, Day, Year) f death (Item 23a) (Type, Print) 30. Name and address of pe 147 32. Registray's Signature

DHMH 16 Rev 6/95

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month 30 AM 1999 BOAT WRIGHT JEDRGE DEZ 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Name (If not institution, give street and number) HOSPITAL BARTIMORE 1 ERCY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Deys Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 6. Sex 100 M 20 F 249-20-338 Usuel Residence of Decedent SOUTH CAROLINA Yrs. 10d. Inside City Limits 10b. County 10a State 10c. City. Town or Location 1 XYes 2 □ No MARYLAND BALTIMORE CI 10e. Street and Number 10f. Zip Code 10g/Citizen of Whet Country? 740 GROVE ST., PLAR 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes: 13. Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexicen, Puerlo Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3℃ Widowed 4 Divorced BLACK 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) RED LINE TRUCKING CO. 7 HTGRADE TRACTOR TRAILER DRIVER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BO ATWRIGHT ERIC NANCY ABLE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) BALTIHORE MD. 21207 Dete 20c. Location - Ofty or Town, Stele 3418 KIMBLE ROAD CLYDE BOATWRIGHT SON 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Dete 1 Burial 2 Cremetion 3 Removel from Stete 01-03-2000 BALTIMORE, MARYLAND 5 Other (Specify) 4 Donatigo ARBUTUS CEMETERY 22. Name and Address of Fadility BROWN JR. FUNERAL HOME JOSEPH H. BROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTIHORE, HD. 21217 21. Signatern of Funeral Service Lion 21 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Tutracerebral Bleed Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence ot): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algoriticant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No 25. Wes cese reterred to medical 26. Place of Deeth (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpetient 3 DOA 28c. Injury at Work? 27, Manger of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Naturel

Physician /Medical Examiner sicien and buriel-transit

Physician

* /Medical

Examiner

Director

Funeral

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Funeral

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7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed within .
Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "n, any injury or other traument.

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72 hours after

Maryland 21215-0020

Baltimore

Examiner Physician/Medical ð Completed Be Certification:

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physicien s the burie signed by t peen has certificate this After deeth.

Box 68760 Records, P.O. Division of Vital after deeth Director: /

24 hours a To the Hosp within 24 hor To the Fune completely fi

State Registrar

Medical

29b. Signeture end title of certifier

Investigetion

6 Could not be determined

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

29c. License number

28e. Plece of Injury - At home, tarm, street, tectory, office building, etc. (Specify)

📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end manner stated. 29d. Dete signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

BACTIMONE

1 ☐ Yes 2 ☐ No

1999

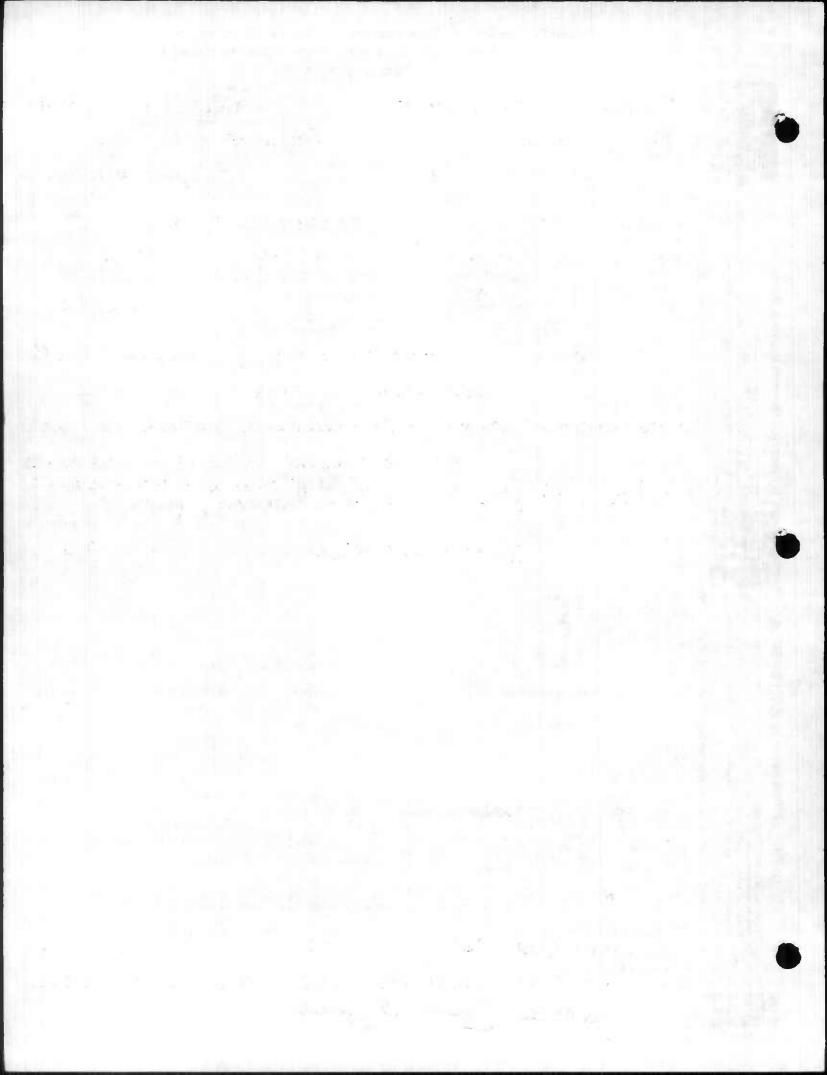
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30. Neme end eddress of person who completed ceuse of deeth (item 23e) (Type, Print)

COSNA PAUL 505 HAT MD 301 55 31. Dete tiled (Month, Day, Year)

32. Registrar's Signeture JAN 0 5 2000

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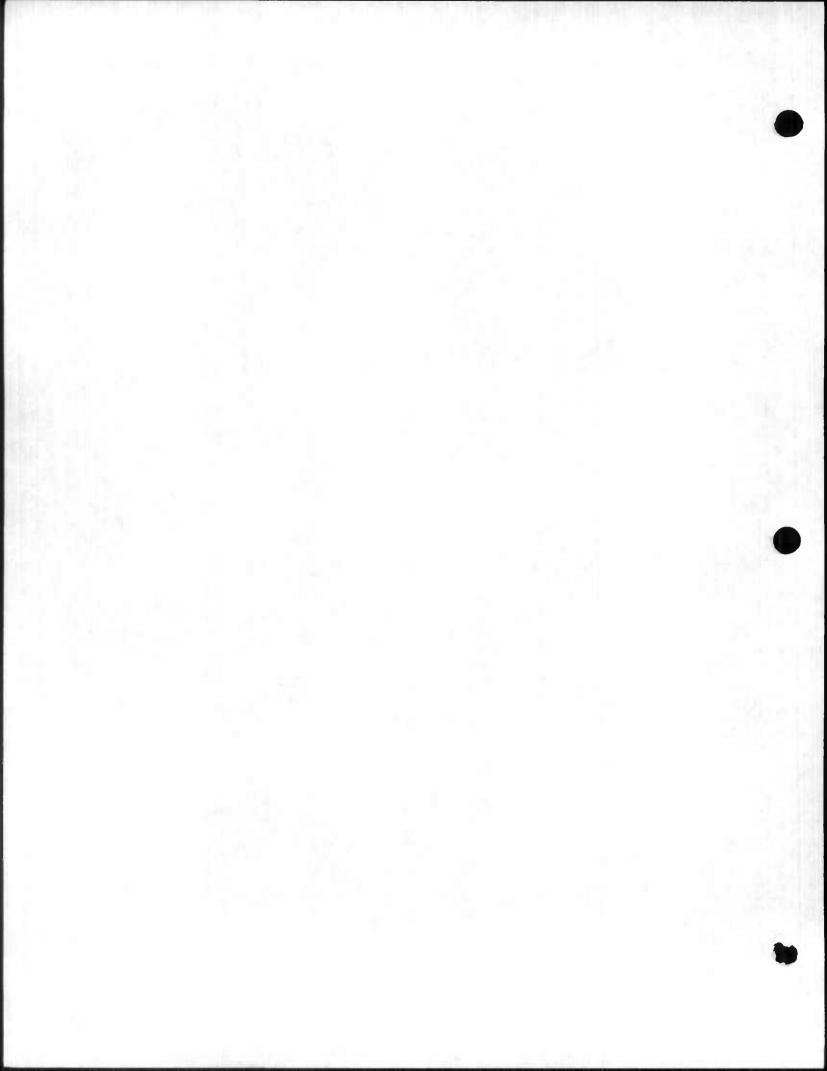


VOID CERTIFICATE # 99-4/600

SEE

CERTIFICATE M

2000-CERTIFICATE
NUMBERED GNDER
1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Day Vear **Physician** 9:20 AM EDWARD WILLIAM BEERE DEC 28 1999 /Medical 4a Facility Neme (If not institution, give street and number) 11630 GUENARM RD. 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GION MEADOWS RETIREMENT HUME GUEN ARM If Under 24 Hrs. 8. Da BAUTHORE If Under 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Hours Min Days Director 213-18-1580 JUNE 17, 1916 MD Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director MD BAUTIMORE GLEN ARM 24 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? ò than "natural", or items 23s or the Wedical Examiner must be U.S.A Funeral GUEN ARM RD -64 11630 21057 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, White, etc. 72 hours after 1 Never Merried 2 Merried 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 Divorced Year or Detes WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Menial Hyglene. artt: If Item 27 Is marked other than ' ury or other traumatic event, ma Ma Elementery/Secondery (0-12) College (1-4or 5+) 12 INSPECTOR ROYAL INSURANCE BOILER Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be MARTIN BEERE MARY MEBER 19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L-64 CTENARM MD. 21057 Dete 20c. Location - City or Town, Stete SPOUSE 11630 AUDIZET BEERE GLENARM RO 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) DEC. 30. 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) DUANT VALLEY MEM. GOWS. 1999 TIMONIUM, MD 21. Signeture of Funeral Servica Licensee 22. Name and Address of Facility EVANS FUNDRAL CHAPEL 8800 PARKVILLE, MO HARFORD RD. 21234 23a. Party Enter the disease, or shock, or heart failure. emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Instery Examiner Examiner MITTEREST. Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): Pert II. Other algrifficant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown Records, py 90 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No of Vital 25. Wes case referred to medical exeminer? Be 26. Place of Death (Check only one) To Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Thesidence 8 Other (Specify) 1 Yes 2 No 2 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 27. Menner of Death 28d. Describe how injury occurred Certification: 28c. Injury et Work? Affise Division Attending 1 Netural 5 Pending 1 Yes 2 No Investigation 2 Accident after desti Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29e. Certifier Medical (Check only one) Tothe Tothe 29b. Signeture and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

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31. Dete filed (Month, Day, Year)

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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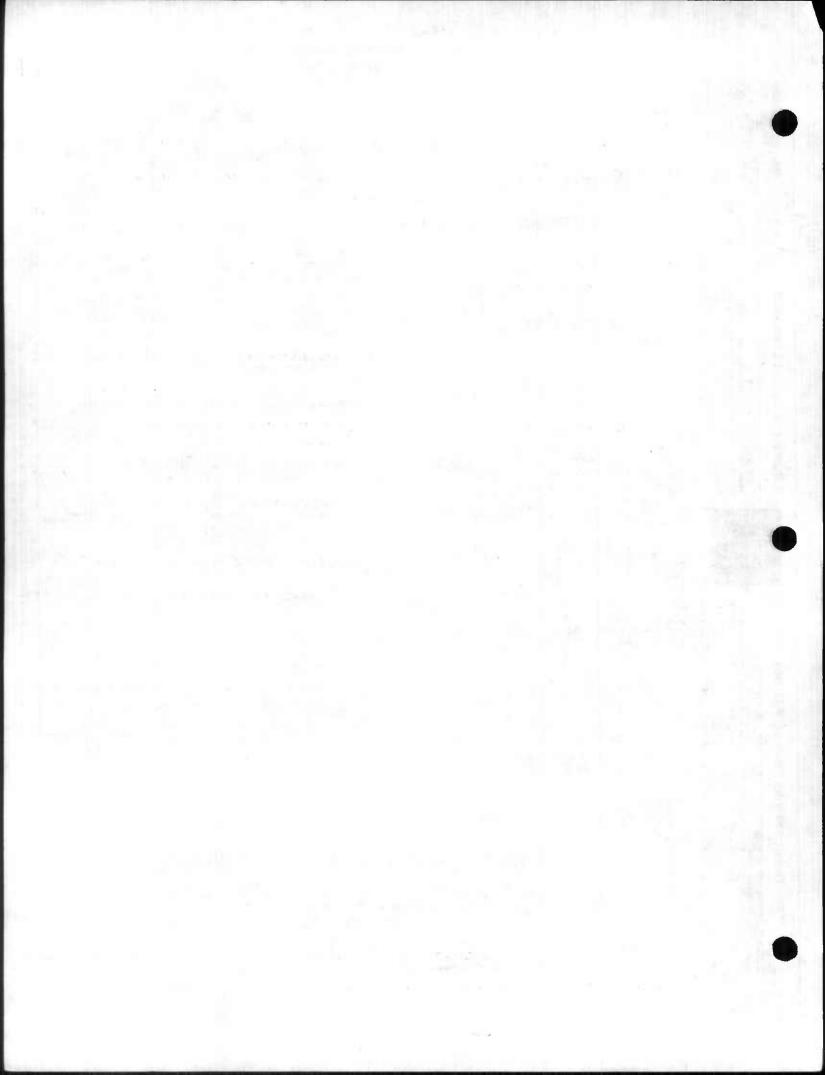
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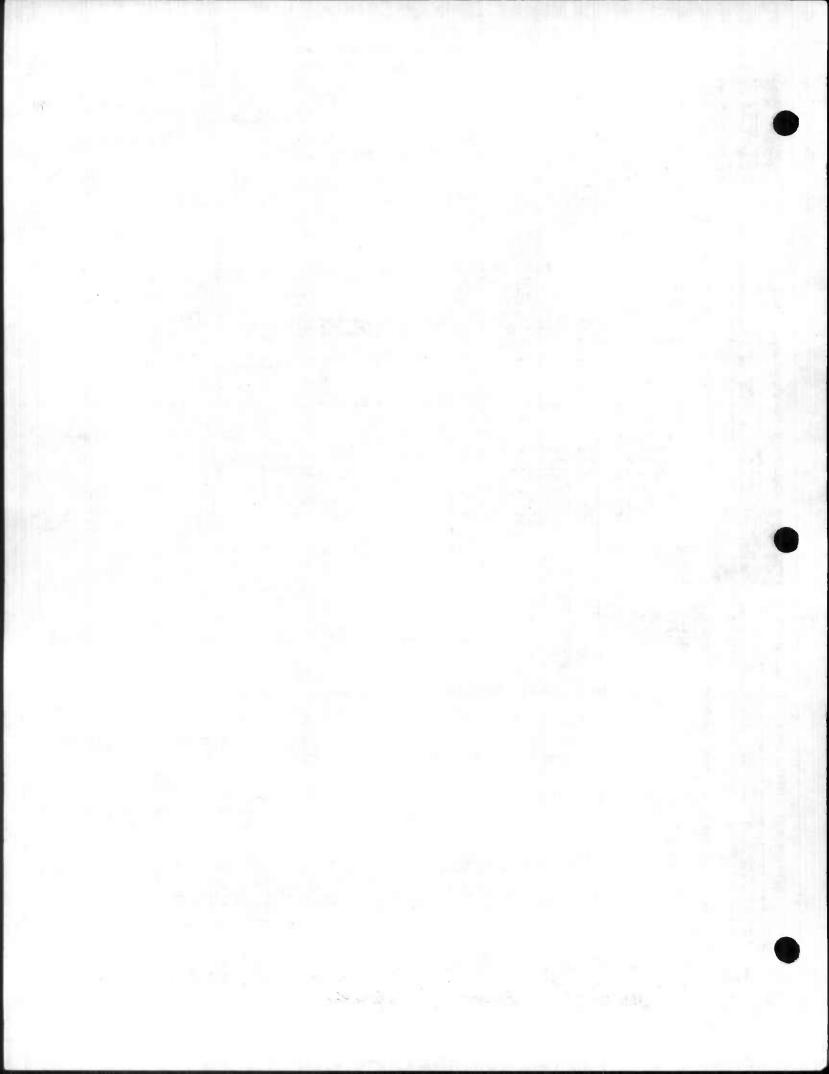


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State of Maryland / Department of Health and Mental Hygiene

		Decedent's Nan	na (First, Middle,	Last)		Се	rtifica	te of	Death	2. Data of [99	4 1 6 0 2 3. Time of Death	
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/Medica Examine		4a Facility Name	If not institution,	ive street and numb	oer)				4b. City, Town,	or Location of Dea		y of Death	411	
, Examine	"	STELLA	MARIS						TOWSON	V	BALT	IMORI	Ξ	
Funeral		5. Social Security I	Number 6	Sex 7.	Age (In yrs.	last birthday,			If Under 24 H	rs. 8. Date of E			place (State or Foreign	
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To the Hospital or Attanding within 24 hours efter death. To the Funeral Director: After completely filled in by the funeral Madinal Completely filled in by the funeral Madinal Completely filled in the funeral formal fo	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 286. Place of	Injury - At h , etc. (Special	ome, larm, st	reet, factor	y, offica			(Street and Num own, State)	ber or Ruri	il Route Number,	
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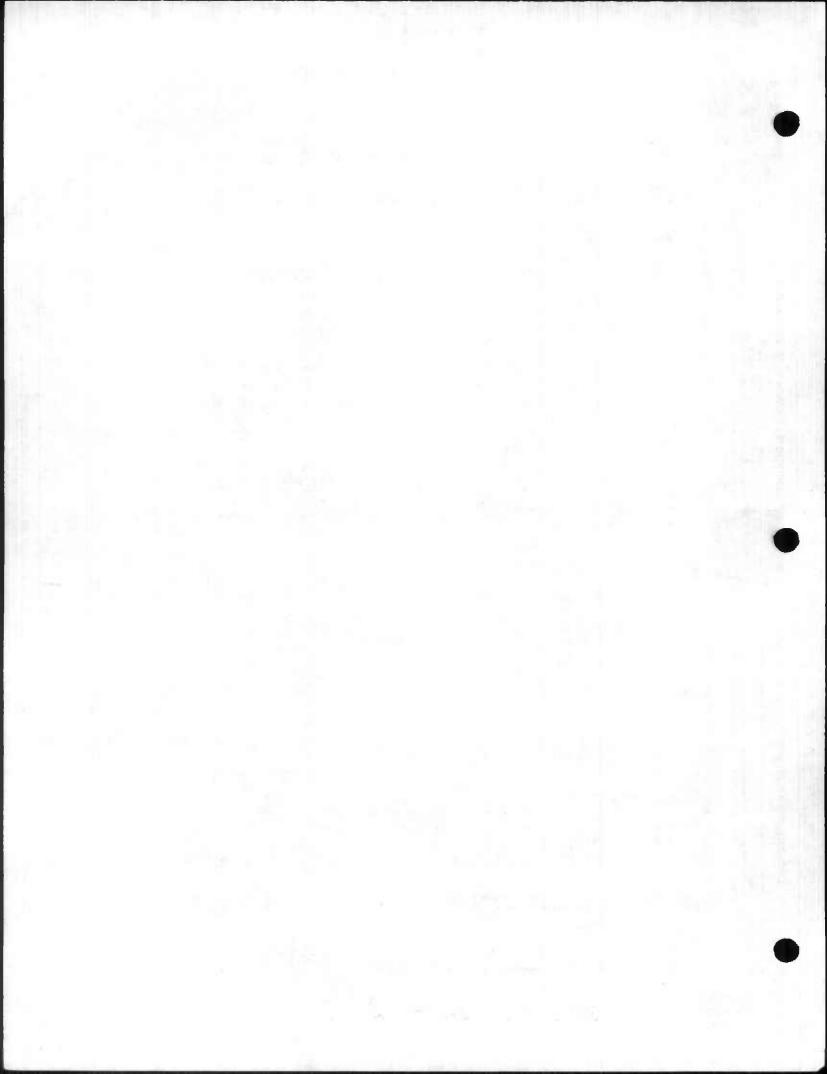
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Des Month Year **Physician** Garrett Branch December 24 0322 1499 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Union Memorial Hospital If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) Aug 7, 1958 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 M 2 □ F 41 Director 213-72-6400 Usual Residence of Decedent 10b. County N/A the Maryland 10a. State 10d. Inside City Limits 10c. City Town or Location Baltimore MD TY Yes 2 No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 21217 USA 1712 N. Fulton Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Stalus 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify: 21215-0020 Specify: à black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) unknown disabled none unknown Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 and 2 ahould be fill ment of Health and Mental H antt if Nem 27 is marked off lury or other traumatic even Be unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 201 E. University Pkwy Baltimore, MD Union Memorial Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 4 ☐ Donation 5 🖾 Other (Specify) instate 21. Signature of Funerel Service Licensee ROnald ²² State Anatomy Board 655 W. Baltimore Street Wade, Director me Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Sepsis duceks Examiner Due to (or as a consequence of): Examiner d weeks -11V ettending physician end for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Ď 24b. Were autopsy lindings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 X No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) This 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. efter death the 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, larm, street, lactory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours of To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) 29d. Dale signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier AT 2438946 WD December 29, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201 E. University Parkney Baltimere, MD Harrison Johnson MD 21218 Union Memoral Huspital 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State JAN 0 5 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene : 100 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Inckne 99 Junna /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SANDTOWN WINCHESTER NURSING CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 8-7-1896 Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□ M 2□ F 220-32-2182 103 Director MD. Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ehow. r than "natural", or Nama 23a or 28a-f ahov the Medical Examinar mant be notified at Yes 2□No Director MD. N/A BALTIMORE 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 MOSHER ST. 21217 USA death , Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK by 3√ Widowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12-BEAUTICIAN COSMETOLOGY 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nant of Haalth and Mental 27 is marked of ABRAHAM L. RUSSELL RUBY WEST 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BETTY RUSSELL(NIECE) 350 KEARNY DR. OWINGS MILLS, MARYLAND 21117 Item 27 20b. Place of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, Stete cemetery, crematory or other place) permit. Pages Department of Important: If It eny injury or o 1 Buriel 2 Peremation 3 Removel from Stete ARBUTUS MEMORIAL PARK 5 Other (Specify) 1-5-2000 BALTIMORE, MARYLAND 4 Donation 21. Signature of Funeral Service Licenses 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 0 23e. Part 1/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 0 work Examiner Due to (oras a consequence of) Examiner VACON burial-transit The law requiras that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Box 68760 50 Physician/Medical tha Due to (or as a consequence of): 8 950 signed by the et d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. P.O. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 200 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 2 s has cartificata 1 Yes 2 NO 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: funaral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Aftar 5 Pending investigation 1 Natural 2 Accident 1 Yes 2 No 24 hours after death. 6 Could not be determined 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. edical 29a. Certifier completaly (Check only one) Within 2 \$ 29b. Signature are little of dertifie 29c. License number 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 33a) (Type, Print) Movermen wo 32. F 5 2000 pistrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death Dev Month **Physician** ELLis James Dacember 29, 1999 0105 /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore o F Maryland 5. Sociel Security Number If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) If Under 1 Year 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 2□ F Months 22438 483 Usuel Residence of Decede 66 Director June 23, 1933 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits 28a-f show the Medical Examiner must be notified at MO BALTIMORE 1 Nos 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò USA 21217 "natural", or items 23a TRICKER ST 1008 Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11. Meritel Stetus Black, White, etc. 72 hours after 1 Yes 2 No 1 Never Merried 2 Merried aitimore, Maryland 21215-0020 Black 1 Yes 2 100 Specify þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "re eny filury or other traumatic event, the Med Botica. Elemantary/Secondery (0-12) College (1-4or 5+) HARLEM TACK CO. NOUL MAKER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be HERMAN CURRI MARITA F. MORRIS 19a. fnforment's Neme/Ralationship (Type, Print), 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) BALTO.MD 21217 WIFE 1008 N. STRICKER ST JOSIE 20b. Plece of Disposition (Name of cemetary, crematory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 MBuriel 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) BALTO. MD Jan.04,2000 OUDON PARK 22. Name and Address of Facility
TRI-STATE 21. Signeture of Funerel Service Licensee FUNBEAL SERVICE WINDRTH AVE. 2/201 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feilure. List only one cause on each line. Approximeta Interval Between Onset and Death **Physician** /Medical Immediele Causa (Finel inferior Infaretion diseese or condition resulting in deeth) myocardial Examiner Due to (or as a consequence of): Examine sttending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequence of) Box 68760 Physician/Medical Due to (or es e consequence of): Pert If. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 2 Onknown à t ☐ Yes 2 ☐ No signed be del Records, p 24b. Were autopsy findings available prior to Completed 24a. Was en autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Attending Physicien: 25. Wes casa raferred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient this funaral 27. Mannar of Death 28e. Date of Injury (Month, Day Year) 28b. Time of tnjury Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 PNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi 2 Accident 6 Could not be determined 3 Suicide 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicida 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to tha cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted. 29b. Signetura end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45857 30. Name end address of person who completed cause of daeth (ftern 23a) (Type, Print) NINO MARYLAND MEDICAL 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State Registrar JAN 052000

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Manyland	r ahow rd at	Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location					side City Limits	
death with the Maryland	3a or 28a-f a st.be nothled	10e. Street and Number 2818 SEABUK	ON PA	LTIMORE 101. Zip Code 212	225	10g. Citizen of What				
5 2	natural, or frame 23a or 28a-f show olds! Examiner must be notified at eted by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U,S. Armed Forces?. 1 Yes 2 No II Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cubs 1 Yes 25 No	ispanic Orlgin? (Sp	ecity Yes or No- Rican, etc.)	ify Yes or No- ican, etc.) 14. Raca - American Indian, Black, White, etc. Specify: Black			
2121 d within	_ = -	15. Decedent's Ed (Specify only highest gre Elementary/Secondary (0-12)	Sa. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired PACL	during most of work	ing	FACTORY				
	To the	17. Father's Name (First, Middle, Last)	CLARK		Louis	ame (First, Middle, Maiden Sumeme) SE MCFAODEN				
	or other traum	19a. Informant's Name/Relationship (1) LOUISE MCFI 20a. Method of Disposition	DDBN S	of Disposition (Neme of	iom A	VE BAL	10.1	State, Zip Code, MD 21 City or Town, St	1225	
time	ndury .	1 Burial 2 Cremation 3 4 Donation 5 Other (Specification 2). Signature of Funeral Service (specification).	Removal from State	T. ZLON	Jan	1.08,001	AND	SDOW	V, ML	
Ba a	impo any li	23a. Part 1. Enter the disease, or com shock, or heart feilure. List only	M. Colcal	22. Name and Addre				Appro	2/20/ eximate rel Between	
//N	ysician ledical aminer	Immediate Cause (Final disease or condition resulting in death)	a. PNELLOWS	AND DATTY	LIVEN			Onse	and Death	
best	in and hel-transit Examiner		Due to (or es	a consequenca of):	- 11					
68760, ficate be axecuted	physician and s the buriel-transit edical Examir	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	a consequenca of):						
BOX 68	tending ph or use as th an/Med	resulting in death) Last	d			-				
P.O	been signed by the attending should be detached for use a leted by Physician/Me	Part II. Other significant conditions or	en in Part I.	23b. Did tobacco use contributs to the cause of de						
	20 0			24a. Was en	eutopsy led?	24b. Were au available completi ol death?	prior to on of cause			
	is certificate ha director, page To Be Com	25. Was case referred to medical			26. Place of Dee	th (Check only one		1 Yes	2□ No	
of Vita Physician:	this ceral direction	XX 162 2 140		Outpatient 3 DOA Oth	4 Nuising no	ome 5 Reside				
Division of Vital	on on	27. Manger of Death 1 Netural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Dey Year)	o. Time of Injury 28c. Injury Wor 1	yat k? Yes 2 □ No	28d. Describe how injury occurred				
DIVI	led in by	4 Homicide determined	28e. Plece of tnjury - At home, building, etc. (Specify)	larm, street, fectory, office		28I. Location (Str City or Town,		per or Rural Rout	e Number,	
To the Hospital of	pietely fill		yalcian: To the best of my knowled itner: On the basis of examination and manner stated.						ause(s)	
Toth	0	29b. Signature and title of certifier	helpie	29c. Licens	e number .M.E	29	DEC.	27, 19		
	OF 3	30. Name and address of person who of	11.	a) (Type, Print) L Penn Street	, Baltimo	ore, Mary	land 2	1201		

State Registrar

MARLA MONTH, Dev. Year)
JAN 05 2000

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June 1 House X = \$237.71.579 A Comment of the Comm Y ASH NA 44.63.44 A STATE OF THE STA ELLIN CITY OF THE BUT SENDON HIS BUT IN THE BUT OF THE SENDENCE OF THE SENDENC All the second of the second o ADITION TO THE STATE OF THE STA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month 6:15 Am Dec uctuda Croom Dawson 4a Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County oi Death 3918 Woodridge Road Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 7. Age (In yrs. lest birthday) 5. Sociel Security Number 6. Sex Birthplace (Stete or Foreign Country) 1 □ M 2 🗗 F 89 217-20-85/6/ Usuet Residence of Decedent Yrs. Carolina Jun 29 1910 North 10e. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Nes 2 No MI Baltimore 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? U.S.A 9918 Woodridge Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Maritei Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1□ Yes 2⊡ No Specify: Black 3 Widowed 4 □ Divorced 16a. Decedant's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Etamantary/Secondary (0-12) College (1-4or 5+) Domestic Domestic 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Surneme) ROXIER Dawson onah 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) BAITIMORE, MD 21229 3918 Woodridge Rd. FrankLIN ANNA JEAN 20b. Piece of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removei from Stata PINELAWN MEMOTIAL JM6,00 North Carolina 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Ronald Ar Gray Son Funeral Service 8312 Alberty Rd Baltimore MD 21244 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiador raspiratory arrast, Approximata Approximata Interval Between Onset end Deeth immediete Ceuse (Finel diseese or condition resulting in deeth) Dua to (or as a consequence of) Sequantially list conditions, if eny, leading to immediate ceusa. Entar Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last Due to (or as a consequence of): Due to (or es e consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco usa contributa to the cause of death? 1 TYSS 2 No 3 □ Probably 4 □ Unknown 24b. Wara eutopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐ No 25. Was cesa refarred to medical exeminer? 26. Ptece of Death (Check only ona) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Deta of injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be datarmined 3 ☐ Suicide Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, daath occurred et the time, dete end piece, end due to the ceuse(s) end mennar es stated. 2 Madical Examinar: On the basis of examinetion end/or investigetton, in my opinion, daath occurred at tha tima, data end piace, and due to the causa(s) end menner steted. 29a. Certifier

615/AM 12/31/99 To the Hospital within 24 hours a To the Funeral I

Registrar

Physician

/Medical

Examiner

Director

Funeral

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Completed

Funeral

Director

from 27 is marked other than "natural", or froms 23a or 28a-f show other treumstic event, the Medical Examiner must be notified at

permit. Pages 1 end 2 should be filed within 72 hours aftar Department of Health and Mental Hygiona. Important: If Item 27 is marked other than "natural", or item any injury or other treumatic event, the Medical Exemption

Physician /Medical

Examiner

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the attending physician hed for use as the buria

signed by the

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Physician/Medicai

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To

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Baltimore, Maryland 21215-0020

31. Date filed (Month, Day, Year)

KODEUT

29b, Signature and title of certifier

(Check only one)

JAN 052000

30. Neme and eddress of person who complated cause of death (Itam 232) (Type, Print)

- vulin 32. Registrer's Signeture Senewa

Entaw St. 139 Ho Md 21201

29d. Date signed (Month, Day, Year)

Date of the said MARKET SERVE LONG LYNNHOLD STEE ROX EX PHYSE P. Y. S. LELLY I. Mean WHALL WAS DO ARTHY TO CHARLE Rome Edillion Baregue

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

VERNIC

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death	00	1.150	
Certificate of Death Reg. No.	22	4100	

CA	ANTY					Ce	rtificat	te of	Death	R	eg. No.	9 1	11000
			1. Decedent'a Name (First, Middle, La	st)				_		2. Date of Dear	th	V	3. Time of Death
	Physici		VERNICE	2				A	UTV	Month DECEMBE	R 31,19	Year 199	4;28P.M.
	/Medic		4a Facility Name (If not institution, giv		1				4b. City, Town, or I	1	4c. County		1,201 111
7	Examin	er	614 N.CARROLLTON					. 16	BALTIMO	RE		N	1/2
	Francis		Social Security Number 6. S		e (In yrs.	last birthday)		r 1 Yeer		8. Date of Birth		9. Birth	place (Stete or Foreign ntry)
	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9 14-26-633/ 1 M 2 F 7. Age (In yrs. last birthday) Yrs. 1 Months Days Hours Min. 1 MARCH 22, 1930									Sou	TH CAROLIN	
	Pud m		10a. State 10b. County 10c. City, Town or Location								100		10d. Inside City Limits
	Many	5	MARWAN	IA				131	PLTIHO	DE C.	7/		12 Yes 2 □ No
	the 1	Director	10e. Street and Number	7/7		1		p Coda	12//170		On Citizen of V	Vhat Cou	ntry?
	with		614 NORTHC	7000011	-7771 (14.15			211	17	,		0
	eath re 23	era	11, Meritel Status	12. Was Decedent				dent of k	Hisnanic Origin? (S	pacify Yas or No-		S Ameni	can Indien,
0	72 hours after death with the Manyend natural; or items 23s or 28s-f show diest Examinar must be notified at	Funeral	1 Never Merried 2 Married	Armed Forces	PINO				Hispanic Origin? (S an, Mexican, Puert	o Rican, etc.)	Blac	k, White,	
02	Mrs a	Completed by	3 ☐ Widowed 4 ₺ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🔀			ZAN NO	Specify:		Specify	BI	-ACK
5-0020	natural',		15. Decedent's Ed (Specify only highest gra	fucation		16a. Dece	dent's Usu	al Occup	pation	rking	16b. Kind of B	ısiness/Ir	dustry
21	c • .	9	Elamantary/Secondary (0-12)		mpleted) (Give kind of work done during most of life. DO NOT use retired)					Ning		1	
2121	d with	NO	12 HAGRADE		HOMEMI					e	OWI	U/	tome
P	al Hygid other	Be	17. Fether's Name (First, Middle, Last,		18. Mother's Name					ne (First, Middle, I	Maidan Suman	na)	
Maryland	s i end 2 should be filed within I Health and Mental Hygiene. Iam 27 ia marked other than other traumatic avant, the M	0	NAPOLEON			CA	NTI	/	BEUL	AH M	AE	JA	MES
ary	2 should and Men is marks		19a, tnformant's Name/Relationship (Type, Print)	-	19b. Maili	ng Addres	s (Street	end Number or Ru	ıral Route Numbe	City or Town,	State, Zi	p Code)
Σ	alth ar 27 ia r trau		LISA SPENCE	(DAUG	HTER	673	05	ECC	SNOMORN	INGCT: (TOLUMB.	IN M	0,21045
ē,	f Health fam 27 other tr		20a. Method of Disposition		20b. I	Placa of Dispo	sition (Na	me of			20c. Location -		
9	Pages nent of I nrt: If its iry or of		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		11.		1		,	11-17-11	1 4.40		15 11A01114
altimor		- 1	21. Signature of Funeral Service Light		17	1, 216	Name a	nd Addre	ass of Facility	01-01-00	LANDE	Jun	E, MARYLAN
Ba	Departi Importa any Inju			,)		J	058	= PI	4 H. BR	20WN JA	e. Pun	ER	AL HOME E,MD.2121
			John will	turns)		0	2140	ON.	FULTE	NAVE,	BALTI	MORI	=,MD.2121
			23a Part1. Entar the disease, or com	plications that cause one cause on each I	d the deat ine.	th. Do not en	er the mo	de of dyl	ng, such as cardiad	or respiratory arr	ést,	1	Approximate Intervat Between
	Physician												Onset and Death
	/Medical		Immediate Cause (Final disease or condition	Hyperter	sive	Arter	iosc]	Lero	tic Cardi	ovascula	r Disea	se	
	LAGIIIIICI		resulting in death)			or as a conse							
	D is	Examiner		b —								1	
	death certificate be executed e attending physician end of for use as the burial-transit	Хал	Sequentiatly list conditions,		Due to (or as a conse	quenca of)):					
30,	de ex		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or Injury	6									
09289	hysic the b	edical	that initiated events resulting in death) Last	C.	Due to (d	or as a consec	uence of)	:					
_	ng p	N N											
Box	eath cer attendir for use	Physician/M		d									
		SC	Part II. Other significant conditions of	ontributing to death b	out not res	sulting in the u	nderlying	cause gi	ven in Part I.	23b. Dld to	obacco use co	ntributa	to the cause of death?
P.0	a y	t S	Dia							1 🗆 Y	08 25No	3 Pro	obebly 4 Unknow
	es tha igned be de	by	DIABETES MELLIT	us									
ecords,	quire on sig uld t	8								24a. Was a	n autopsy	24b. V	Vere autopsy tindings vailable prior to
00		let								INSPE		0	ompletion of cause f death?
Re	The law ate has b page 2 s	Completed								1D Y	as 2X No		☐Yes 2☐No
a	certificate rector, pag		OF Man one referred to medical								E A	1	
Vitai	Physician: this certific rel director,	o Be	25. Was case referred to medical axaminar?	Hospital:		3 = 0.00		Ot Ot	har:	ath (Check only or		40	* .
of	£ 50		1 Yes 2 No 27, Manner of Death	1 L Inpati		28b. Time o		UA	4 🗆 ivursing r	lome 5 Resid			ny)
	After fune	5	1 Natural 5 Panding	28a. Data of tnji (Month, De	y Year)	Injury	м	28c. Inju Wo	rk?]Yes 2∐No	200. 0 0000100 11	on injury coods		
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Division	or Attandate death	Certification:	4 ☐ Homicide determined	28e. Placa of In building, a	c. (Speci	ioma, farm, st	reet, tacto	ty, onica		City or Tow		701 01 110	07710010 140111001
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	To the Hospital or Attanding I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical		ysician: To the best niner: On the basis of	of examina								
	thin a plan	Med		and manner st	ated.		20	o Licen	se number		29d. Date signe	d (Month	Dev Year)
	S T S		29b. Signature end title of certifier	1 11		2	25	Jo. LICUN	30 110111001	-	.ou. Date signe	a (word)	Doy, von)
			- UNI	. 00	m.	().		0.0	C.M.E.	J.	ANUARY	1,20	00
-	N .7-		30. Neme and address of person who	completed cause of	death (Ite	m 23a) (Type,	Print)						

State Registrar

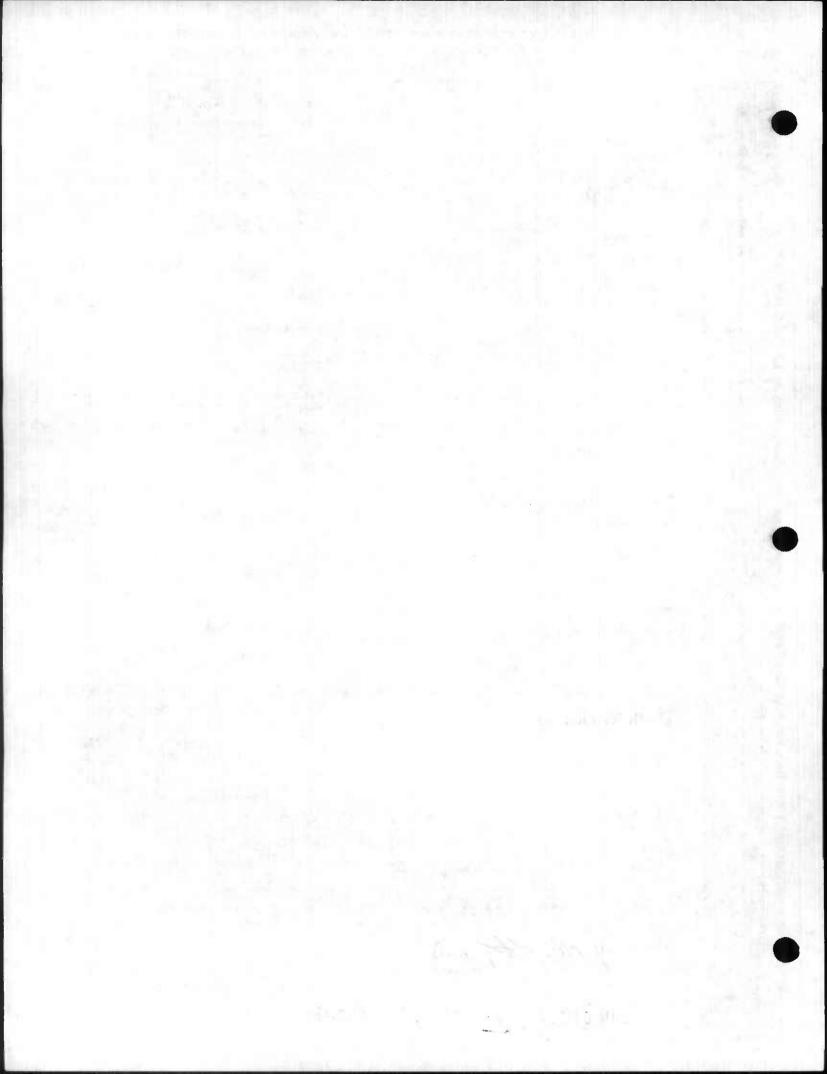
31. Dete filed (Month, Dey, Year)

JACK M.TITUS MD.

JAN 052000

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death COOPERMAN DECEMBER 31 MILTON 1999 7:11 a.m. 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death THE JOHNS HOPKINS HOSPITAL N/A BALTIMORE CITY # Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 83 yrs Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number Months Days MM 2DF 067-09-3041 NOV 14 1916 NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yas 2 □ No **OUEENS** WOODHAVEN 10a, Street and Number 10f Zin Code 10a. Citizen of Whet Country? 11421 83-85 WOODHAVEN BLVD APT. 6 U USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, atc. 1 Never Merried 2 Married TY Yes 2 NWW II 1 ☐ Yes 2 No Specify: Specify: WHTTE 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) SALESMAN LIQUOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumama) **COOPERMAN** SZABO CHARLES FRIEDA 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) SHARON COOPERMAN/DAUGHTER 19341 KEYMAR WAY GAITHERSBURG, MD. 20886 20e. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Flemoval from Sar MT. ARARAT CEMETERY 1/3/2000 FARMINGDALE, NY. 4 Donat Othar (Spec 22. Name and Address of Fecility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 e, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest. Immediate Cause (Final 2 YEARS ADRTIC STENOSIS disease or condition resulting in deeth) Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings evailable prior to completion of cause of death? 24e. Was an autopsy 1 ☐ Yes 2 No 1 Yes 2 No 26. Placa of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manger of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Netural

The law requires that the death certificate be axecuted Box 68760, P.O. Records. s been signe should be page 2 certificate Division of Vital Hospital or Attending Physician:

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After

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s after death.

within 24 hours a To the Funeral D

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2

Examiner Physician/Medical à Be Completed Certification: To

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: if Item 27 is marked other than "natural", or item any Injury or other traumatic event, the Medical Farman

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

à

Completed

Be

0

with the Maryland

death

25. Wes case referred to medical axaminar? 1 Yes 2 No

2 Accident

3 Suicide

29e. Certifier (Check only one)

4 Homicide

5 Panding investigation

6 Could not be determined

28a. Dete of Injury (Month, Dey Year)

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) end manner as stated.

Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier

29c. License number RES-000

29d. Date signed (Month, Day, Year) December 31, 1999

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

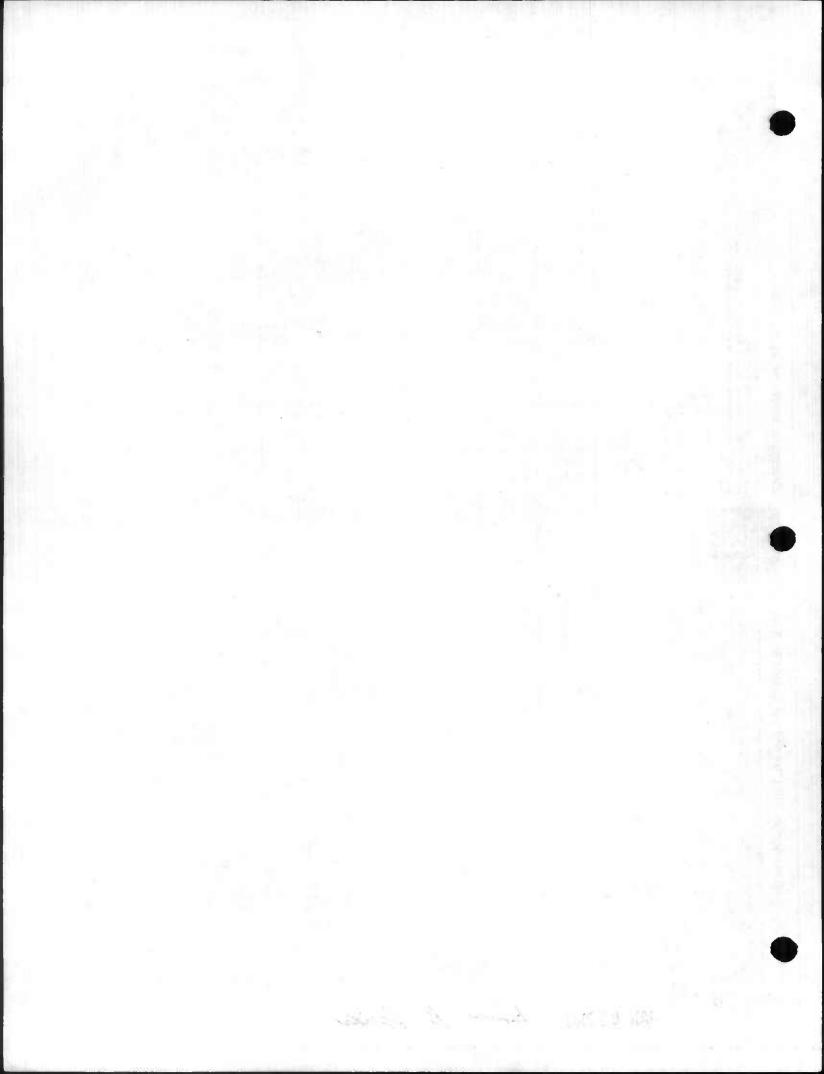
Wolfenden. MD. Johns Hopkins Hospital, 600 North Wolfe Street, Maryland Linda

State Registrar

0 5 2000

31. Data filed (Month, Dey, Year)

32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 6 10 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Kathleen Month **Physician** 6:45 pm herry DEC /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Je HIMONE If Under 24 Hrs. 8. Dele 0 MURISILU 1cn4land 7. Age (in yrs. lest birthday) if Under 1 Yee 8. Dele of Birth (Month, Dey, 9. Birthplece (State or Foreign 5. Social Security Number 6. Sex **Funeral** 216-36-9770 Usuel Residence of Decedent Months Days Hours Mary 1□ M 2□ F Yrs Director with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1+1more 1 HYes 2 No N 288-1 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 1201 venia 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Reme Race -11. Marital Status American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ Ne If Yes, Give Year or Detas: 1 Never Merried 2 Merried 1 Yes 2 No Specify: À Specify: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DQ NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry I Hygiene. College (1-4or 5+) omestic 124 17. Father's Neme (First, Middle, Last) 18. Mothar's Neme (First, Middla, Maiden Sumame) Be Department of Health and Mental Important: If Item 27 is marked of any injury or other traumatic eve alme 19e. Informent's Neme/Raletionship (Type, F 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Baltimore Melinda 20c. Location - City or Town, Steta 20b. Plece of Disposition (Neme of cemetary, crematory or other place) 20a. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) remetor 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility Milken Enterphisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory in the cause of a cause or a cause o 21213 Approximete intervel Batween Onsat and Death **Physician** /Medical Immediate Causa (Final diseasa or condition resulting in death) Examiner Examiner 07 ii or Attending Physician: The law requires that the death certificate be executed after death. I Director: After this certificate has been signed by the attending physician and d in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Dua to (or es a consequence of) Completed by Physiclan/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 ☐ Yes 2 No 1 Yes Be 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturat 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be detarmined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) To the Hospital or Attention 24 hours after des To the Funeral Director completely filled in by the 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Cartifier Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one)

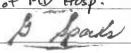
State Registrar

LAMONT 31. Dete filed (Month, Day, Year)

29b. Signature end title of certifie

MD Univ 32. Registjar's Signeture 0 5 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



29c. License number

D0052950

29d. Date signed (Month, Day, Year)

Dec. 31, 1999

DHMH 16 Rev 6/95

21215-0020

Baltimore, Maryland

Box 68760.

Division of Vital Records, P.O.

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99-7673-510 Certificate of Death Frank D. Duvall 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death De **Physician** Frank David Duvall Jr. 12/22/99 1:00 AM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University Hospital Baltimore City
If Under 24 Hrs.
Hours Min.

Min.

Min.

May 14, 1978 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Funeral Months Days 1 XXM 2 ☐ F Maryland 21 214-92-0852 Director Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show MD N/A Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ð 1705 Hollins Street 21223 Nems 23a USA Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 ≜Yes 2 □ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Maritef Status permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mentel hygiene. Important: if Hem 27 ie marked other than "natural" or language injury or other traumatic event 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: Black P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Warehouseman Stadium 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Frank David Duvall Sr. Jane Savickas 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Savickas (Mother) 1705 Hollins Street Baltimore, Maryland 21223 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremetion 3 □ Removal from State Mount Zion Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 01/04/2000 Lansdowne, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Caple Funeral Service 5502 Winner Avenue Baltimore, Maryland 21215 complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Contact Gunshot Wound of Head Examiner Due to (or as a consequence of): Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequenca ot) Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ٥ 24b. Were autopsy tindings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 1 XYes 2 No V☐ Yes 2□ No 25. Was case reterred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1) Yes 2□ No Certification: To 1 ☐ Inpatient 2 X ER/Outpetient 3 ☐ DOA this 28b. Time of fnjury 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 5 Pending 1 Natural To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 Yes 2 No investigation 12/22/99 12:35 AM 2 Accident Subject shot self 3X Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide 1705 Hollins St., Balto., MD Home Medical 29a. Certifier 🔟 Copyring Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. ner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

DHMH 16 Rev 6/95

The lew requires that the death certificate be associated

Box 68760.

Division of Vital Records, P.O.

Attending Physician:

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State Registrar

29b. Signati

JAN 0 5 2000

John Smialek,

31. Date filed (Month, Day, Year)

s of person v

Penn St., Baltimore, MD 32. Registrer's Signature

111

no completed cause of death (Item 23a) (Type, Print)

Sparker

ORIGINAL

W

29c. License number OCME

29d. Date signed (Month, Day, Year)

January 5, 2000

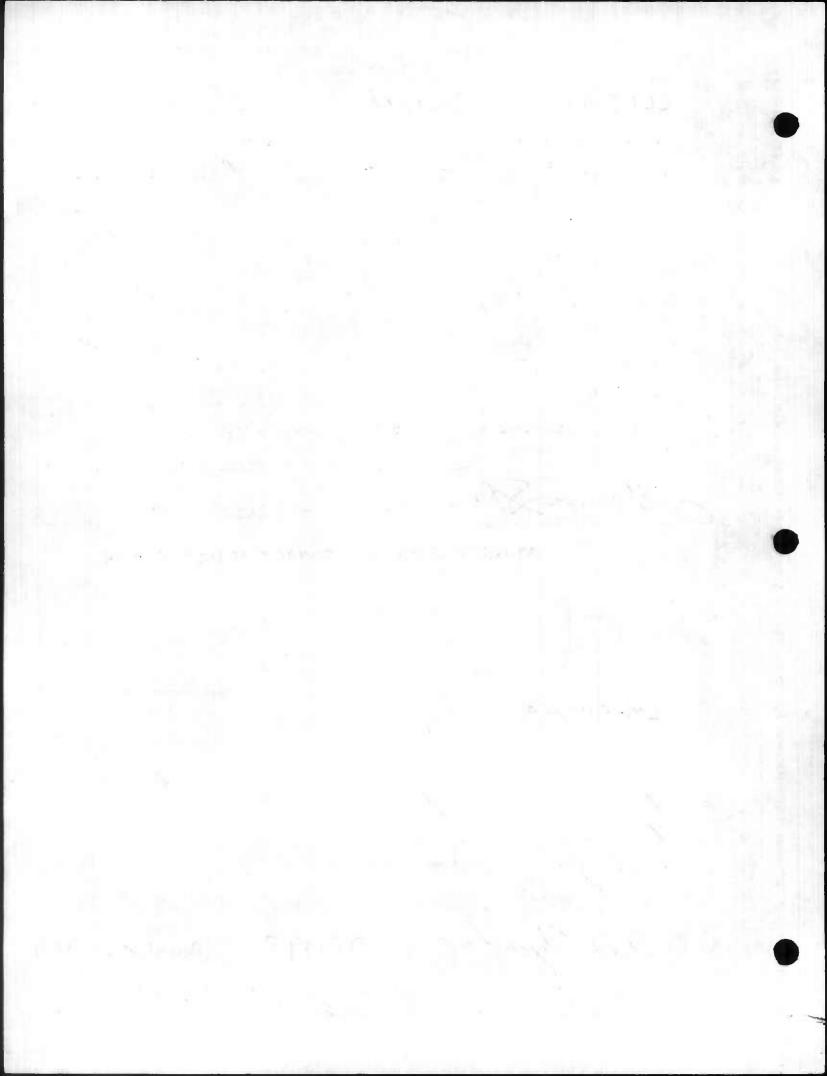
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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				Otate of W	iai yiai i		ificate of	Death		Reg. No.		· ·	
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1	Funeral			6. Sex 7. Ac	ge (In yrs. I	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Data of Bir (Month, Da	th	9. Birthpli	aca (Stata or	r Foraign
	Director		214-18-6763 Usual Residence of Decedent	1 X]M 2□F	77	Yrs.	Months Days	Hours Min.		.5 22	Count	.C.	
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	H 128	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Count	ry?	
	h wit	O is	2105 Ridgehi	11 Ave			212	17			S.A.		
	8 8	ner	11. Marital Status	12. Was Decedent Armed Forces	Ever in U,	S. 13. W		tispanic Origin? (Si an, Mexican, Puert	pecify Yes or No	- 14. Rac	ce - Amarica		
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a	d 2 should h and Men r le marke treumatic		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailing	Address (Street	and Number or Ru			State, Zip	Code) 21	.239
_	Health Health om 27		Robert Frankl	in-Nephew		1615	East N	orthern	Parkw	ave Ba	ltim	ore M	
altimore,	8 7 E		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation :		20b. P	lace of Disposi	tion (Nama of story or other pla		Data	20c. Location	· City or Tov	wn, State	
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att	Department of Important: If any Injury or once.		21. Signature of Funeral Service Li	censee	-	22.1	Nama and Addre	ss of Facility	J/.2000	UWING	5 111	1137	110
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	Physician /Medical Examiner	iner	Immediate Causa (Final disease or condition resulting in death)	ATHER		EROTI	- C. C. C. C.	LONARY	ARTE	Y DU	EAVE		
,0	ficete be executed g physician and as the burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	0.	Due to (or	as a conseque	ence of):				-		
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a	certificate rector, pag		25. Was case referred to medical			,		00 Plant 4 Page	10		10	Yas 201	NO
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	or Attending effer death. Director: After I in by the fune	Certification:	3 Suicide 6 Could no detarmin	t be			et, factory, office		28f. Location (City or To	Street and Numi wn, Stata)	ber or Rural	Routa Numi	ber,
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	ert		30. Nama and address of person w	to completed cause of c	death (Item	23a) (Type, Pr	rint)					1	
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	Sta Registr	te ar	31. Date filed (Month Day Year)	32. Régistr	ars Signal	g g	Source						

DHMH 16 Rev 6/95



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x 68760,	nding physician and use as the buriel-transit	- 1	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or that initiated event; resulting in death)	nmediate orlying injury	c		Due to (or as											
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Division	Hospital or Attanding P 24 hours after death. Funeral Director: After t haly filled in by the funeral		3 Suicide 4 Homicide	6 Could n determi	ot be ned 28e. Pl	ilding, et	c. (Specify)		eet, factory, offic				City or To	own, S	State)		iral Route Number,	
	To the Hospital or At within 24 hours after To the Funeral Direct completely filled in by Madical Carriel		(Check only one) 29b. Signature and	2 Medical E	Physician: To Examiner: On the and m		examination a			у ор	pinion, death			, date	and place	, and due		
		3	10. Name and addr	_	who completed c						C.M.E.		altimo				19,1999 1 21201	
	State Registrar		11. Date filed (Mon	th, Day, Year)	32		ar's Signature	5	Spa	-								

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Nathaniel 0655 Kua la 6 51 30 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mercy Medical Baltwire Bultimera If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 2 M 2 □ F ZZO 42 8226 Usual Residence of Decedent 3 Md Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits M Balto 1 Yas 2 No Funeral Director d 10e. Street and Number 10f. Zio Coda 10g. Citizen of What Country? 2157 706 U. S. A 1218 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apocify Cuban, Mexican, Puarto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Datas: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Black Completed by 3 ☐ Widowed 4 🖹 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Buainess/Induatry Elementary/Secondary (0-12) College (1-4or 5+) Worker STeeL 2 DL 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) HAWKINS MARYC N Mose ENGLAN4 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant'a Name/Retationship (Type, Print) permit. Peges 1 and 2 a Department of Health or Important: if item 27 is any injury or other trau pncs. md. 21218 2151 BALTO. 706 ARY ENG 20b. Place of Disposition (Name of cemetary crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 Cremetion 3 Removal from State artulus mam. Pd 3/2000 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Locks nocks 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Examine Physician/Medical Examiner auco Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of). Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 25 No 25 No 1 Yes 25. Was case referred to medical axaminer? Be 26. Placa of Death (Check only one) 1 Yea 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 28a. Data of tnjury (Month, Day Year) 28d, Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Vatural

Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, atreet, lactory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier

The law requires that the death certificate be executed Box 68760. P.O. Division of Vitai Records. or Attanding Physician:

with the Maryland

filed within 72 hours after death

Peges 1 end 2 should be filed within nent of Health end Mental Hyglene. int: if item 27 is marked other than

attending physician and for use as the burial-transit

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After

funeral

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Maryland

Baitimore,

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"natural",

traumatic avant, the Medical Examiner must be notified at

To the Hospital or Attanding within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year) State Registrar JAN 0 5 2000

D0051891

29c. License number

29d. Date signed (Month, Day, Year)

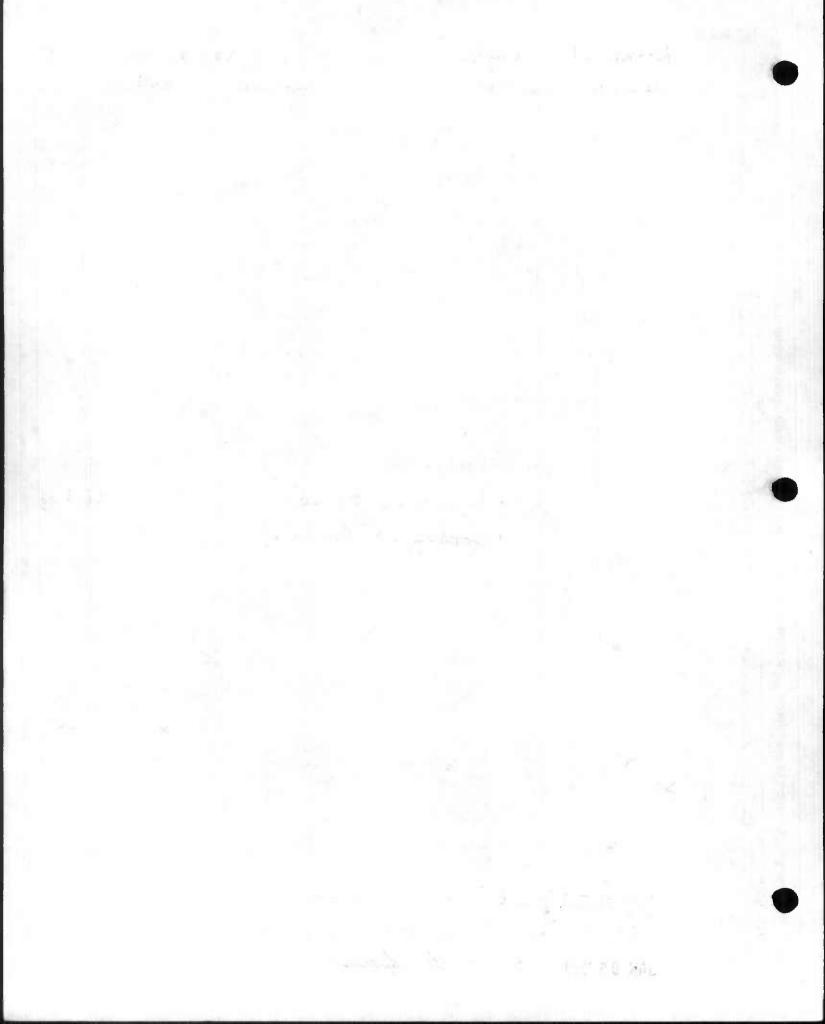
30. Name and address of person who co noleted cause of death (Item 23a) (Type, Print) 301 24

aco

32. Registrar's Signature

(Check only one)

29b. Signature and title of certifier



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Replace ment Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey Month **Physician** RICARdo ECFUMBER /Medical 4b. City. Town, or Lecation of Death 4c. County of Deatl Name (If not institution, give street and gumber) Examiner NA SAV UCEL 01 7. Age (In yrs. last birthday) If Under 24 Hrs 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 18 M 20 F Hours 43 217-66-5488 mo Director 10-15-**Usual Residence of Decedent** the Manylend 10a, State 10c. City, Town or Location 10d. Inside City Limits 10b. County Pages 1 and 2 should be filed within 72 hours after deeth with the Maryle near of Health and Mentel Hypiene. ant: If them 27 le marked other than "natural", or hams 23a or 28a-f ehow mury or other traumatic event, it is the disagramment to another any or other traumatic event, it is the disagramment. 1 Yes 2 No BALTIMORE MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 932 WILMONT 2/202 USA 07 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK à 3 ☐ Widowed 4 ☐ Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) LANDSCAPER College (1-4or 5+) 12th grade LABORER 1/4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) EdWAR MAE JAMES ANNIE AYES 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAMELA 932 WILMONT Edw ARdS C7 BALTO. mp 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Depertment of Important: If it any injury or o 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State GARRISON FOREST VA. 4 Donation 3 Other (Specify) 12/281 OW INGS mILLS 1129 NO CAROLINEST 22. Name and Address of Facility 21. Signature of Funeral Survice Licensea BETTS FUNERAL HOME BALLOMD Ullo 2/2/3 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth hysician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or sel a cortsequence of) Physician/Medical Examiner The lew requires that the death certificate be assected anding physician and use as the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated execute. Box 68760. ILKATOR that initiated events resulting in death) Last Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 3 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 XYes 1 Yes 2 No 2 No of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificataly filled in by the funersi director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 10 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 6 ☐ Could not be 28e. Plece of Injury - At home, lerm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23s) (Type; Print) KUHATDA 31. Date filed (Month 32. Registrar's Signeture Registrar

DHMH 16 Rev 6/95



Ja (L

Physiciar /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, or Medical Examinar must be notified at ence.

Physician /Medical Examiner

To the Mospital or Attending Physician: The law requires that the death certificate be exercited the Atoms after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-ty completely filled in by the funeral director, page 2 should be detached for use as the buriel-ty

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible.

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Decedent's Nama (First, Middla, La:	at)		007.00	10010		2. Deta of D	Reg. No.		3. Tima of	Death
DAMON LAMAH		S				Month DEC.	14,1	999 ^{Year}		
4e Fecility Neme (If not Institution, give	a street and number)				4b. City, Town, o	r Location of Dea		ounty of Dea		
	H AVENUE				BALTIM	ORE		•	N/A	
5. Social Sacurity Number 6. S		n yrs. last bii		Under 1 Ya	er If Under 24 Hr	s. 8. Data of B	irth	9. Bi	rthplaca (Stata or	Foraign
214 86 9835	⊋M 2□ F 23		Yrs.	fonths Day	ys Hours Mir	MAR. 6	,1976		RYLAND	
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10e. Street and Number			ľ	10f. Zip Cod	9		10g. Citize	n of Whet C	Country?	
3704 FAIRVIEW	AVE. API	. #4		21	216		U.S	. OF	Α.	
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17. Fathar's Name (First, Middle, Last)					18. Mothar's Na	ama (First, Middl	la, Maiden Si	ımema)		
REGGIE FLOWER	RS				PATRI	CIA WHI	ITENE	R		
19a. Informant's Name/Ralationship (Type, Print)	195	b. Meiling A	Address (Stre	eet and Number or F				Zip Code)	
PATRICIA HARRIO	OTT (MOTHE	20) 3	312	ALTO	DOAD B	ALTIMOR	DE MA	DVIAN	ND 2121	6
20e. Mathod ol Disposition		20b. Place o				Data	_		r Town, Stata	0
1 XBurial 2 Cremetion 3 4 Donation 5 Othar (Specify				CEME	rery 12/	21/99	LANSI	OWNE	, MARYLA	AND
21. Signature of Juparal Service Lipon	Lwyn	YNN	LEW 451	IS T. 7 PAR	K HEIGH		NUE		215-63 . MD.	
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Sequentially list conditions, if any, laading to immediata causa. Enter Undarlying Cause (Disease or Injury	C									
thet initieted avents rasulting in death) Last	Dua	a lo (or as a	consequan	ica ol):						
	d								1	
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						24a. Wa	is an autopsy formed?	, 24b	. Ware autopsy li aveilable prior to completion of co of deeth?	0
						15	Yas 2□	No	1 Was 2	No
25. Was case refarred to medical					26. Place of D	eath (Check only	ona)			
examiner? 14 Yas 2 No	Hospitel: 1 Inpatient	2□ ER/O	utpatient	3□ DOA	Oth			XOthar (Sp	ecify)at sc	ene
27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye		Time of Injury	28c. Ir	njury at Vork?	28d. Describe	-	-		
2 ☐ Accidant Invastigation	12-14-199				☐ Yas 2XX\o	Subjec	ct was	shot.	2.7	
3 ☐ Suicida 6 ☐ Could not be detarmined	28e. Place of Injury building, atc. (5	- At homa, la Specify)			CO	281. Location City or To Baltin	own, Stata)	2107 V	Rural Routa Numi N. North and	Ave
29a. Certifier 1 Certifying Phyone) Conditions 1 Certifying Phyone 2 Medical Example 1	vaician: To the best of finite: On the basis of axis	y knowledge amination an	e, death oc	curred at the	tima, data and plac y opinion, deeth oc	ce, and dua to the	a cause(s) a	nd mannar	as stated.)
29b. Signatura and titla of certifier	10/			29c. Lice	ense number		29d. Data	signed (Mor	nth, Dey, Year)	
4	161				C.M.E.				1, 1999	

State Registrar 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print)

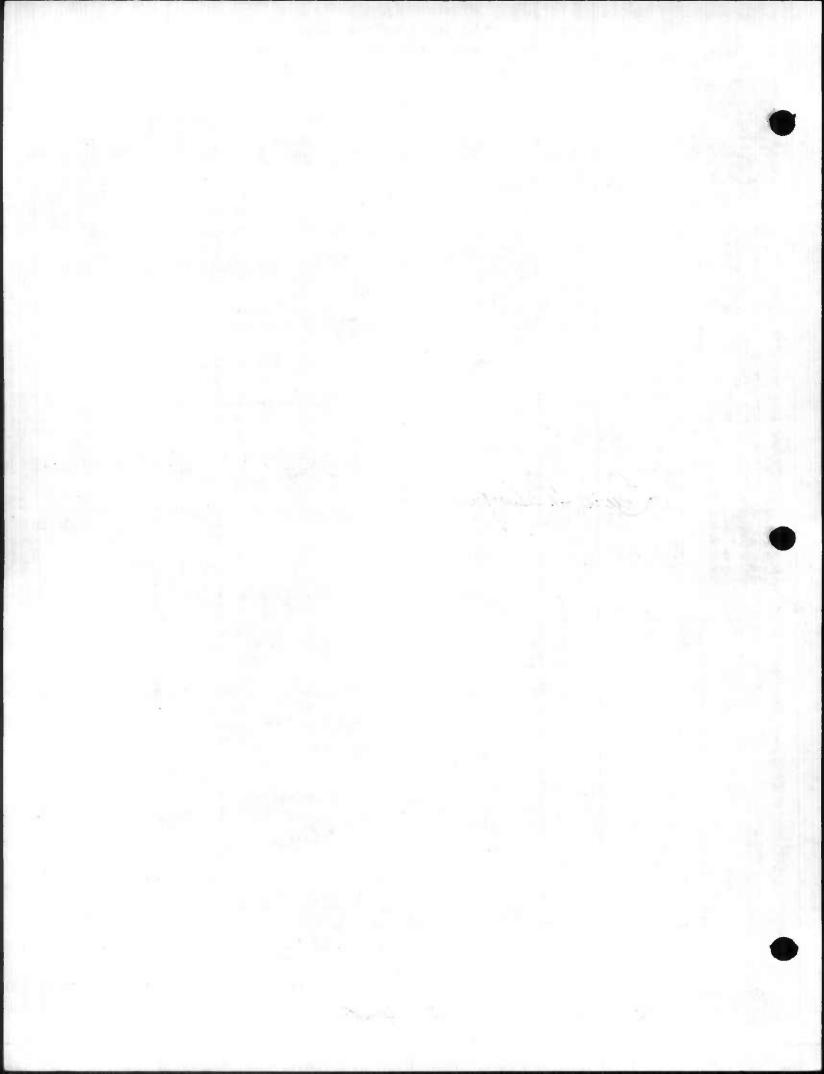
David Fowler, M.D. for J. Laron Locke M.D., 111 Penn Street, Baltimore, Maryland 2120

31. Data filed (Month, Day, Year)

JAN 0 5 2000

32. Registrar's Signeture

Sports



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amended Item#20b, 20c perFH G7802/8/200 Manyland / Department of Health and Mental Hygiene O Certificate of Death Amended Item#1 perPhyG780 2/8/2000 EW 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2 Date of Death Month **Physician** ORENCE HOLLIDAY ecember al /Medical 4b City, Town, or Location of Deeth 4c. County of Death goe street and number) Examiner 8. Dete of Ban (Month, Day ENER 9. Birthplace (State or Foreign Country) 10 SOUTH CAROLINA **Funeral** 1□M 2XF Deys Min Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits over its marked other than "natural", or items 23s or 28s-f show other traumatic event, the Modical Examiner must be notified at Yes 2 No Director MARYLAND 10e. Street end Number 10g, Citizen of Whet Country? 528 2/2 3

13. Was Decedent of Hispanic Origin? (Specify Yas or NoIf Yas, specify Cuban, Mexican, Puarto Rican, etc.) ICE STREET Funeral 14. Rece - Amarican Indian, Black, White, etc. 12. Wes Decedent Evar in U,S. Armed Forces? 11. Marital Status 1 ☐ Yas 2 ☑ No ff Yes, Give Year or Detes: 1 ☐ Never Marriad 2 ☐ Marriad 1 ☐ Yes 2 No Specify: þ BLACK 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) 11+HGRADE WORKER SELF-EMPLOYED 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Department of Haelth and Mental Important: If Item 27 is marked o Pages 1 and 2 should be DAV15 ISABELLA LEV1 Lo (MN-UNKNOWN) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Reletionship (Type, Print) 15215,3151 (DAUGHTER) STREET AHILADELPHIA, PA. MATTIE WHITE timore. 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition LANSDOWNE Burial 2 Cramation 3 Ramoval from Stata ò VARY CE METERY 01-10-00 4 ☐ Donetian 5 ☐ Other (Specify) BALTIMORE, HARYLAND any injury 22. Name end Address of Facility BROWN JR. FUNERAL HOME -ULTON AVE. BALTIHORE, MD. 21217 23a Payl. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiac or respiratory afrest, or heart feiture. List only one cause on each line. Approximata Intervel Between Onset end Deeth Physician Immediete Ceuse (Final disaese or condition resulting in death) /Medical Examiner Due to (or as e consequence Examiner Teumono physician end the buriel-transit Sequentielly list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): certificate be exec Physician/Medical Due to (or es a consequence of): USB BS 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown à Division of Vital Records, 24b. Were eutopsy findings eveilable prior to completion of causa of deeth? 24a. Wes en eutopsy performed? Completed certificate has 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicel examiner? Be 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 Inpatient 2 ER/Outpetient 3 DOA this luneral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28c. Injury et Work? After t Certification: 1 Neturel
2 Accident or Attending 5 Pending e Hospital or Attending n 24 hours efter death. e Funeral Director: Afte 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicfan: To the best of my knowledge, deeth occurred et the time, date end plece, and dua to the ceuse(s) end menner as sfated.

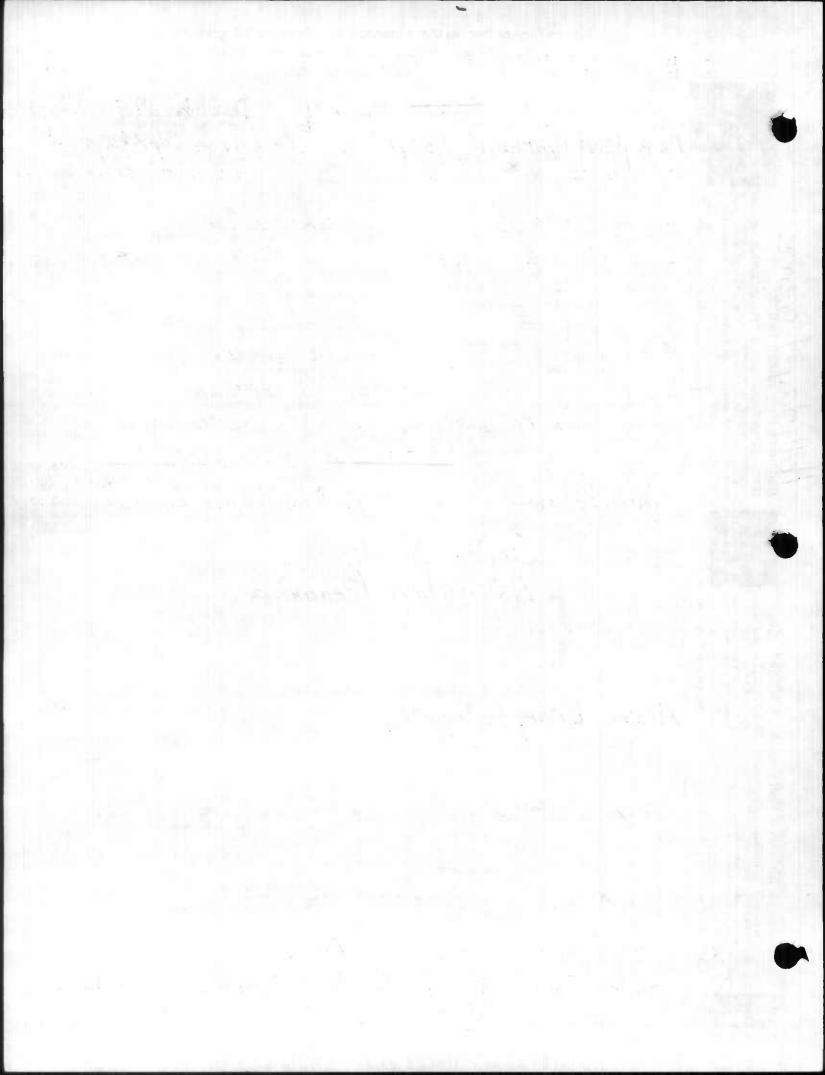
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end menner stated. 29a. Certifier Medicai completaly (Check only one) To the F within 2 29b. Signeture end title of certifier 29c. Licansa number 29d. Data signed (Month, Dey, Year) 12-30-99 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) MARYland GENERAL Hospital

32/Registrar's Signeture

State Registrar

31. Dete filed (Month, Day,

JAN 0 5 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Dey Month Year **Physician** ARTHUR E HOLDREN 29 Dec. 1999 11:05pm /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Dundalk

If Under 24 Hrs.
Hours Min.

Hours Min.
Dec. 16 1919 Heritage Center Baltimore If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days M 20 F Months 236-18-3779 81 Director WestVirginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Show item 27 is marked other than "natural", or itema 23a or 28a-f show other trsumatic event, the Medical Examinar must be notified at MD Middle River 1 ☐ Yes 2 No Baltimore Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 21220 USA 3 Right Wing Drive Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indien, Bieck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 72 hours after No. If Yes, Give Year or Dates: 1 Never Merried 2 Merried Baitimore, Maryland 21215-0020 White 1 ☐ Yes 2 € No Specify: Specify 2 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "1 any Injury or other traumatic event, the Head Middle River Elementery/Secondary (0-12) College (1-4or 5+) Machine Company 12th Machinest 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Nama (First Middle Last) Be Ethel Blanch Lilly Walter D. Holdren 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Baltimore Md. 21220 Douglas McKinney /grandson 3 Right Wing Drive 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, cremetory or other place) Data 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) 1/3/2000 Baltimore Md. Metro Crematory INc. 22. Name end Address of Facility 21. Signeture of Funeral Service Lice Connelly Funeral Home of Essex 300 MAce Ave. Baltimore Md. 21221 complications that caused the death. Do not enter the mode of dying, such as cardiac or my one cause on each line. **Physician** /Medical Immediate Cause (Fine) diseese or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) å physician a the burial-Box 68760 Physician/Medical Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown signed by à 8 24b. Wara autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was casa raferred to medical examiner? 88 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 1 28d. Describe how injury occurred 27 Menner of Death 28b. Time of Injury Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Affar 1 Neturel 5 Pending investigation 1 TYes 2 No death. toapital or Attand 4 hours after death Juneral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours Furneral Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and mannar as steled.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steled. 29a. Certifier edical (Check only one) Vithin 2 290. Signature and title of certifier 29c. License number 29d. Deta signed (Month, Day, Year) NEORD 08358 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

State Registrar

DHMH 16 Rev 6/95

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31. Dete filed (Month, Day, Year)

JAN 0 5 2000

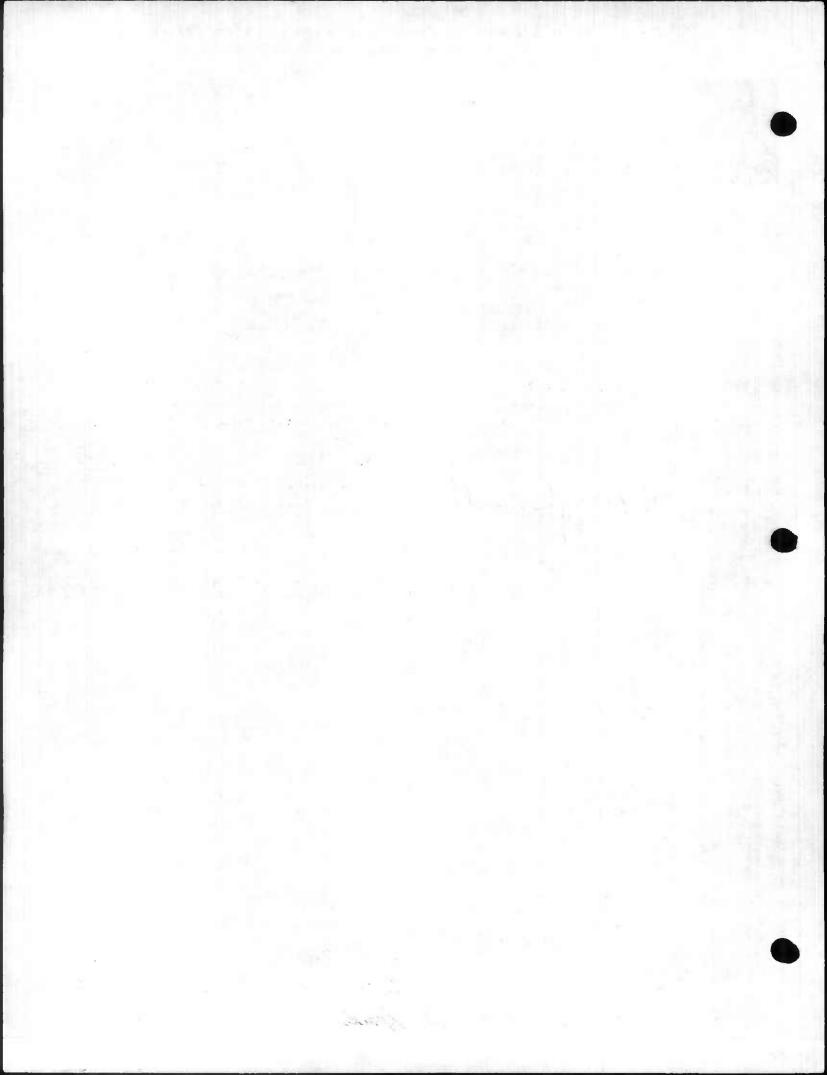
MD

32. Registrar's Signature

TATRICIO

703

CLINTON ST BALTIMORE



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death epher Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death towar c (Um G 0 OWGVO (0 0 PGO If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Yel 10-26-48 Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months 1 MM 2□ F Yrs 51 MD. 212-46-9158 Usual Rasidanca of Decedant 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yas 2 No HARFORD ABERDEEN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 399 STRATFORD AVE. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☒ Yas 2 ☐ No 14. Race - American Indian, Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Black, White, etc. 1 Navar Married 2 Married 1 ☐ Yes 2 ② No Specify: BLACK Specify: 3 ☐ Widowed 4 ☑ Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -12--4-PROBATION OFFICER STATE 17. Fathar's Nama (First, Middla, Last) 18. Mother'a Nama (First, Middle, Maiden Surname) DOROTHY MAE HARPER STEVEN HARPER SR. 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 805 LONG BAR RD. ABINGTON, MARYLAND 21009 BENNIE HARPER (UNCLE) 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 12-31-99 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY 21. Signalury of Funaral Service License 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 VUBne 23a. P. 1. Entar tha diseasa, or complications that caused tha death. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, nock, or haart failura. List only one cause on each line. Approximate tnterval Between Onset and Death Immediata Ceuse (Final diseasa or condition rasulting in death) Sequantially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Disease or injury that initiated events resulting in daath) Last 23h. Did tohacco use contribute to the cause of deeth? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably At Unknown 1 Yes 2 No 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 NO 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical examinar? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2NNo 2 ER/Outpatient 3 DOA 26a. Data of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Tima of 28c. tnjury et Work? Natural 5 Panding investigation 1 Yas 2 No 2 Accidant 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicida

or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A

Physician

/Medical

Examiner

Funeral

Director

must be notified at

289-7

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permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyplane. Introportant: If Item 27 is marked other than "natural", or ther any Injury or other traumetic event.

Physician /Medical

Examiner

and

physician

After this certificate has

funeral director,

filled in by

completely

for use as the buriel-transit

Examiner

Completed by Physician/Medical

Be

Medical Certification: To

29a. Certifier

(Check only

29b. Signatura and titla of certifiar

31. Date tiled (Month, Day, Year)

0 5 2000

30. Nama and address of person lifto complated cause of death (Item 28a) (Type, Print)

32

Baltimore, Maryland 21215-0020

Directo

Funeral

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Completed

Be

MD.

State Registrar

DHMH 16 Rev 6/95

ORIGINAL

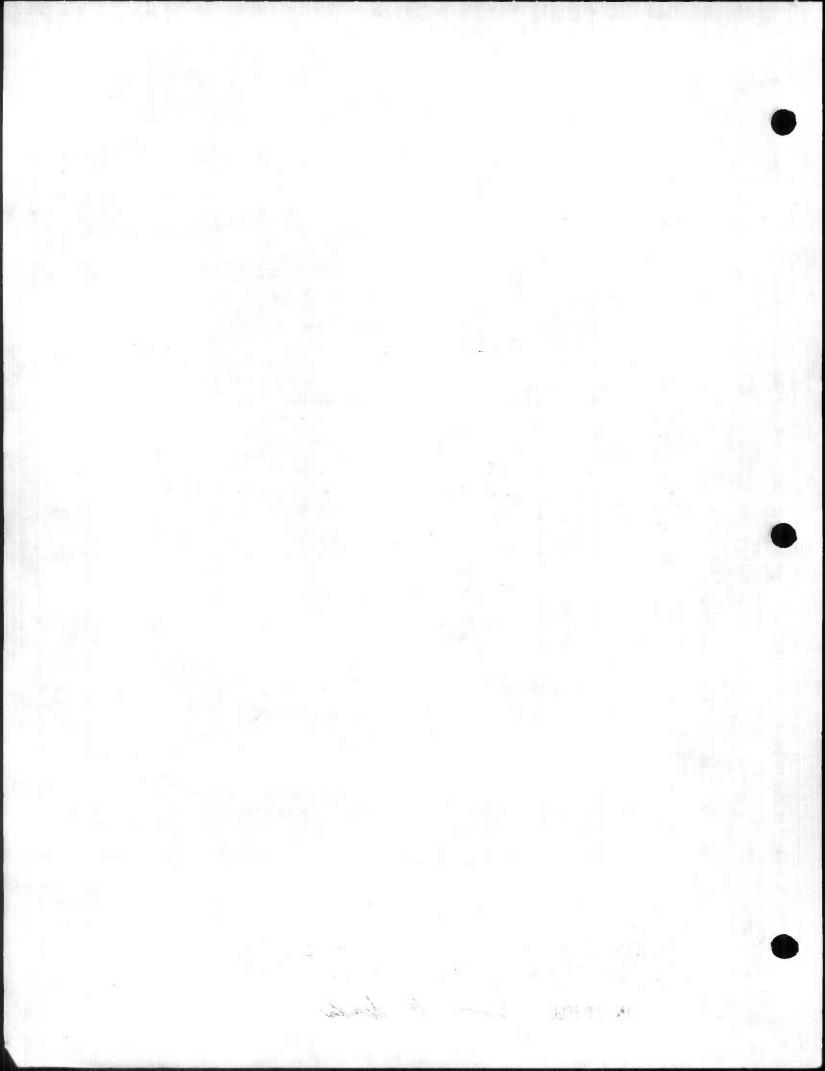
VOV

Registrer's Signeture

To Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 4 620. Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month **Physician** 16:25 Flbert James Johnson 12 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Deeth Examiner tallston General Hospital Fallston Harford If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 38 798 Months 244 38 798.
Usuel Residence of Decedent 1 M M 2□ F 72 Yes North Carolina Director Dec. 18, 1927 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worke pemit. Peges 1 and 2 should be flied within 72 hours efter deeth with the Maryla Department of Health and Mantal Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumstic event, the Madigal Examiner must be notified at Bodg. Harford 1 ☐ Yes 2 XNo Director Maryland lesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Koad 21132 Heaps School U.S.A Funeral 14. Rece - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status 1 ☐ Yes 2 M No If Yes, Give Year or Detes: 1 Never Married 2 Merried 21215-0020 1□ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Black Smith Self Employed 6 yrs. altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 9 Coy Bartlett trancis Maggie 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21132 19a. Informent's Name/Reletionship (Type, Print) School Road Pylesville, Heaps Kathleen Johnson 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete JAN13 Fallston, Maryland Highview Memorial Gardens 2000 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel - Beldir, P. A. 21058
Evans Funeral Chapel - Beldir, Maryland
2 Nowport Drive Forest Hill, Maryland 21. Signature of Funeral Service Licer 21050 23a. Parti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intervel Between Onsat end Death Physician Immedieta Cause (Finel disease or condition resulting in death) /Medical Examiner Obstructive sician and burlat-transit or Attending Physicien: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or es e consequence of) d for use es t been signed by the a should be detached t Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 3 Probably 4 ☐ Unknown 1 Yea 2 No disease artery Division of Vital Records. Completed by 24b. Were autopsy tindings available prior to completion of causa of death? 24a. Was en autopsy performed' 1 ☐ Yes 200 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 Seleturel To the Hospital or Attanding within 24 hours effected.

To the Funeral Director: Afte completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide TS Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature end title of certifier

Registrar **DHMH 16 Rev 6/95**

State

Marie

31. Date filed (Month, Day, Year)

JAN 05 2000

halkan 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

C.C., SAKTAH.

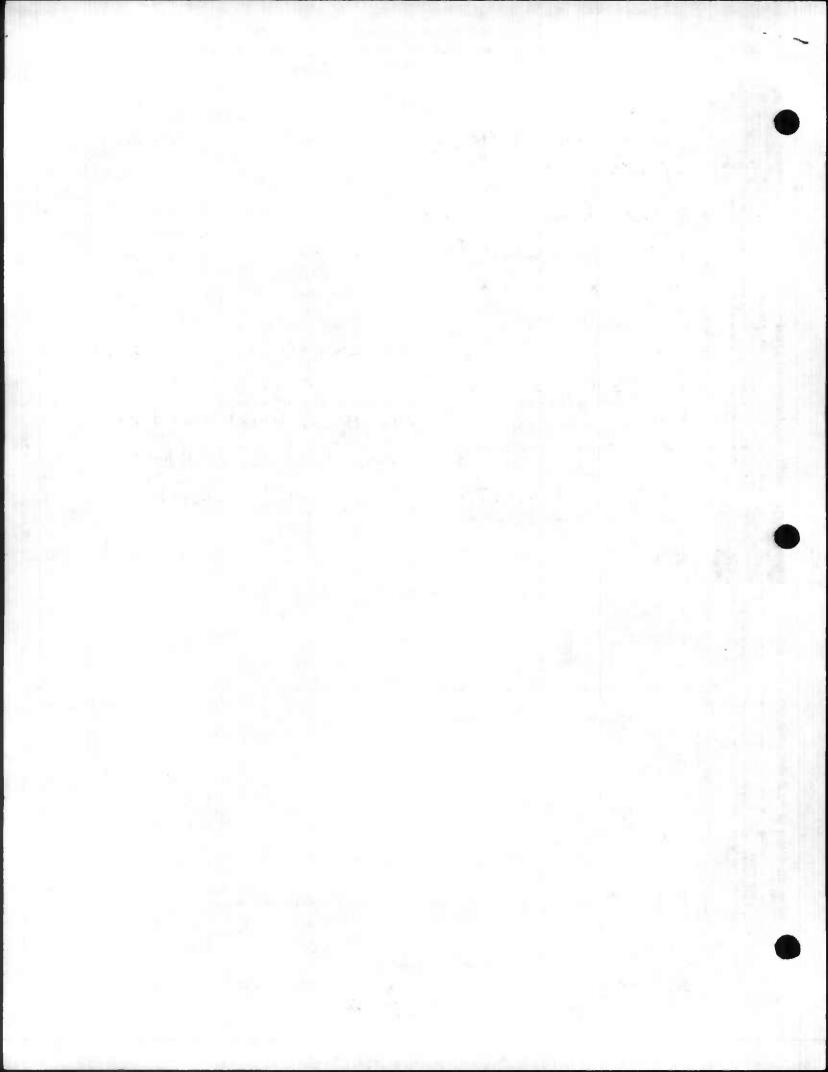
32. Registrar's Signature

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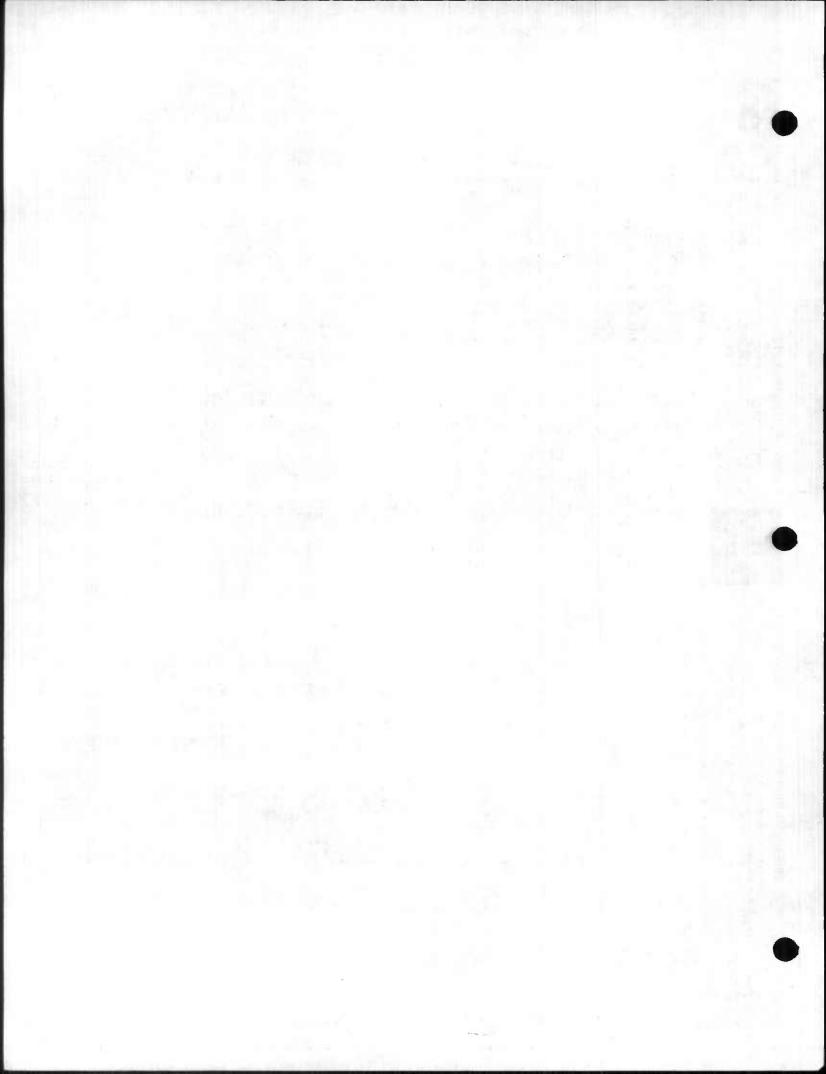
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Q 1. 1. 2.2.1

		State of Maryland	Certificate of		R	eg. No.		106.1
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/Medical	4a Facility Name (If not institution, give			4b. City. Town, or	DECEM &	FR 30	1999	10:35an
Examiner	HARBOR HOSP	•		BALTI		4c. County	1	12
Funeral	5. Social Security Number 6. Se	x 7. Age (In yrs. last	birthdey) If Undar 1 Yeer	If Under 24 Hrs.			9. Birthp	place (State or Foreign
Director	220-76 -1709 1 Usuel Residence of Decedent	DM 214 38	Yrs. Months Deys	Hours Min.	NOV, 2	8,1961	MA	RYLAND
No. of the	10a. State 10b. County	10c. City, T	own or Location				1	0d. Inside City Limits
a Maria	MARYLAND N.	A	BALT	HORE	C171			1 Yes 2 No
vith the Ma to or 28a-f a be notified Director	10e. Street and Number		10f. Zip Code			0g. Citizen of V	Vhat Coun	itry?
	2716 SETHL	OWROAD		212	25	U	SA	
her death verber 23 siner matt	11. Maritel Status	12. Was Decedent Evar in U,S. Armed Forcas?	13. Wes Decedent of I If Yas, specify Cub	lispanic Origin? (S an, Mexican, Puart	pecify Yes or No- o Rican, atc.)		e - Americ k, White,	an Indien, etc.
Dy by	1 Never Merried 2 Merried 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Yeer or Detes:	1□ Yes 2KNo	Specify:		Specify	BL	ACK
I 21215-0 ed within 72 ha yajens. we then 'netur it, the Medical.	15. Decedent's Ed (Specify only highast grad	ucation 1 da completed)	6a. Decedent's Usual Occup (Give kind of work done	during most of wor	tking	16b. Kind of Bu	siness/Inc	dustry
T21	Elementery/Secondary (0-12)	Collega (1-4or 5+)	life. DO NOT use retire	,		01100		11.10
	17. Father's Neme (First, Middle, Last)		CASA	18 Mother's Nan	ne (First, Middle,			KING
Vland Vl	WILLIAM A.	TOHNSON 2ND		h -		MAE	DE	WALL
T T	19e. Intorment's Name/Relationship (7	75.11.0010	19b. Meiling Address (Street				State, Zip	Code)
Mary nd 2 sho nith and 27 is me r traume	DOROTHY M. JOHNS	16.	2716 SET	4/OURC	AN BA	THO		0, 21225
Te Tanger	20a. Method of Disposition	20b. Plece	e of Disposition (Neme of atery, cremetory or other plan	nel .	Dete	20c. Location		
Page mit if ry or	1, Burlal 2 Cramation 3 4 Donation 5 Other (Specify	Hamovai from Stata	10	1	01-03-00	1 palme	ma	WE, MO.
alti	21. Signature of Funerel Service Licens	see	22. Neme end Addre	ss of Fecility	3 Pacalal	TO E	10/E	RAL HOME
m Jac E S S	M(2 - 1)	· On	JOSEP					40.21217
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Physician	and the second s	THE SECOND STATE OF THE SE					1	Onset and Death
/Medical Examiner	Immediate Ceuse (Final disaase or condition	RESPIRAT	DRY FAIL	URE				5 days
	resulting in death)		e consequence of):				1	0
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U _ a -	Cause (Disease or injury that initiated events	· METHICILLIN		STAPH			2EUS	15 days
W = 22 0	resulting In death) Last		a consequence of):			EPSIS		5 years
death certification of for use a sticlan/M		. ACQUIRED IM	MUNE DEFIC	LIENCY	SYNDRO	OME	-	Jacob
. 0 00	Part II. Other significant conditions co	ntributing to death but not resultin	g in the underlying cause giv	ren in Pert I.	23b. Did to	obacco use co	ntribute to	the cause of death?
P.O. that the ed by the detache					1 🗆 Y	• 2 □ No	3 Proi	bably 40 Unknown
ss that as the be de be de								
ords requires een sign hould be					24a. Wes a perfor		eva	ere eutopsy tindings ailable prior to
lec law law nas be 2 sl							of	mpletion of cause death?
Division of Vital Records, or Attending Physicien: The law requires that cleath. Director: After this certificate has been signed in by the tuneral director, page 2 should be certification: To Be Completed by					1 🗆 Y	es PNo	10	Yes 20 No
Of Vita Physicien: this certific ral director,	25. Wes case reterred to medical examiner?	Hospitel:	Cont		eth (Check only or	10)		
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Vision Attending or death. ector: After by the tune	3 Suicide 6 Could not be	28e. Pleca ot Injury - At home			28t. Location (S	treet and Numb	er or Rure	al Route Number,
Div after din b	4 Homicida	building, etc. (Specify)			City or Tow	n, Stete)		
Division of To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely tilled in by the funeral Medical Certification: 7	29a. Certifier (Check only one) 2 Medical Exam	sician: To the best of my knowled iner: On the besis of examination and menner steled.	dge, deeth occurred et the tir end/or investigation, in my o	ne, date end placa pinion, deeth occu	, end due to the c rred et the time, d	ause(s) and me ete end pleca,	nner as si and due to	lated. the cause(s)
o the omple omple	29b. Signetura and titla of certifiar	and more ordered.	29c. Licens			9d. Data signe		
6	▶ Phtch	L					BER.	30 1999
0	30. Name and eddress of person who c	ompleted cause of deeth (Item 23	a) (Type, Print) SATI	SH CHA	NORA.	M.D.		
/ XI	35DI, S. HANC 31. Dete tiled (Month, Day, Year)	OUER STREET,		, MD, 2	11225			
State Registrar	JAN 052	32. Registrer's Signeture	& Spa					
DHMH 16 Rev 6/95	טרוו טטנ	.uuu Cara	N MOO	My				

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#14,15,20a,b,c,21,22 perFH G779 1/19/2000 Gertificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month 10:15 AM Alton Johnson 4b. City, Town, or Location of Death 26 4c. County of Death 4e. Fecility Neme (If not institution, give street end number) ST AGNES HEALTHCARE Baltimore 7. Age (In yrs. last birthdey) 63 yrs If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplece (Stete or Foreign Country) Deys 1 X M 2 □ F Months Yrs. 227-44-4667 Oct 9, 1936 unknown Usuel Residence of Decedent 10c. City, Town or Location Baltimore 10d. Inside City Limits N/A 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 22-30 Athol Avenue 21229 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 No
If Yes, Give
Yeer or Deteanknown 1 Never Merried 2 Married black 1 Yes 2 No Specify: 3 Widowed 4 Divorced Afro-American 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) unknown unknown unknown unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) unknown unknown 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 900 S. Caton Avenue, Baltimore, MD St. Agnes Hospital 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MT ZION CEMETERY 1/18/2000 Balto Co Md 4 □ Donetion 5 Bother (Specify) in state 21. Signeture of Finerel Service Licensee Joseph L. Rus Russ 22 Name end Address of Facility
State Anatomy Board 655 W. Baltimore 21201 Joseph Russ Funeral Home Baltimore, MD 23a. P.1.1. Enter the disease, or complicetins that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Immediate Ceuse (Finel disease or condition resulting in deeth) Myocardial Due to (or es e consequence of) Due to (or es e consequence of): Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Piece of Death (Check only one)

Physician /Medical **Examirier**

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physician the burie

50 USB

Completed by

Certification: To

that the deeth certificete be executed

Box 68760.

Division of Vital Records,

Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica

within 24 hours effer de To the Funeral Director completaly filled in by the

Johnson

Department of Health er important: If itam 27 is any injury or other trau once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

234

Director

Funeral

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Completed

Be

f is marked other than "natural", or items 23a or 28a-f shov traumstic event, the Medical Examiner must be not filed at

Pages 1 end 2 should be filed within 72 hours after death inent of Health end Mental Hygiene. Int: If Itam 27 Is merked other than "natural", or Items 23.

Baltimore, Maryland 21215-0020

the Meryland

Physiclan/Medical Examiner Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Lest

> 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

> > 32. Registrer's Signature

Other: 4 Nursing Home 5 Recidence 6 Other (Specify) 27. Magner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending

2 Accident 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end menner es steted.

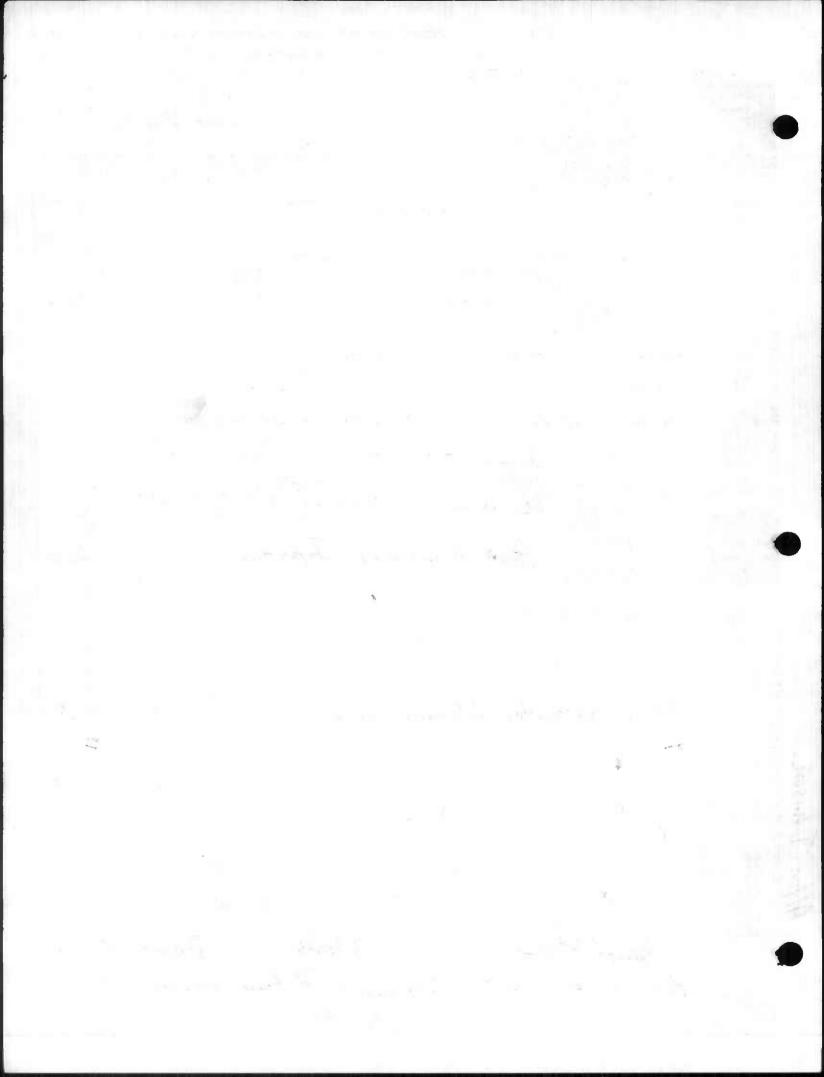
Madical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end manner stated. 29a. Certifier

29b. Signature and title of certifier 29d. Date signed (Month, Dey, Yeer) 29c. License number

December 29, 1999

of person who completed ceuse of deeth (Item 23e) (Type, Print) Baltimore Maryland 21229 900 Caton SCRUGGS MI) 0 5 2000

State Registrar



99-7924-005

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legibie.

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INE	END ITEMS: #23 P		4° Certifica	ite of	Death 19	,		
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/Medical			KIIIIE			DECEMBE	1	
Examiner	4e Facility Name (If not institution, give				4b. City, Town, or Lo		4c. County o	
	8201 PULASKI HIGH 5. Sociel Security Number 6. Se		ast hirthday) If Und	ler 1 Yeer	Rosedal		BALTI	Birthplace (State or Foreign
neral ector		XM 2□F 42	Yrs. Months	s Deys	Hours Min.	8. Dete of Birth (Month, Dey, Nov. 9,	Year) 1957	Country) Maryland
otor	10a. Stete 10b. County Maryland Ba	ltimore 10c. City	, Town or Location	D	undalk			10d. Inside City Limits 1 ☐ Yes 2 🖾 No
tems 234 or 284-f show the must be notified at Tuneral Director	10e. Street and Number 2002 Larkhall Ro	ad	10f. Z	Zip Code	21222	1	Og. Citizen of W United	hat Country? States
by	11. Merital Stetus 1 Never Merrled 2 Narried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U.; Armed Forces? 1 [XYes 2 No If Yes, Give Yeer or Detes: 1976-	1 ☐ Yes	edent of Hoecify Cube	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		- American Indien, s, White, etc. White
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traur	19e. Informent's Neme/Reletionship (T) Mrs. Deborah L.				end Number or Run L1 Road I			
or other	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ f	20b. Pl Removel from State	ece of Disposition (Nametery, cremetory or	leme of r other plea	ce) !	Dete	20c. Location - (City or Town, Stete
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any li	21. Signature of Puneral Service Licens				ss of Fecility Funeral			
	220 Part Februsha du desa or omo	ications that caused the death				undalk,	-	d 21222 Approximete
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completely filled in by the Medical Certific		afcian: To the best of my knowner: On the besis of exeminet and manner stated.						
Comple	29b. Signeture end title of cartifier	11	2	9c. Licens	e number	2	9d. Date signed	(Month, Dey, Year)
	20 Name and address of account	/4	22a) (Time Prim)	0.C.	M.E.	J	ANUARY	1,2000
	30. Name and address of person who c	Powler			Street, 1			

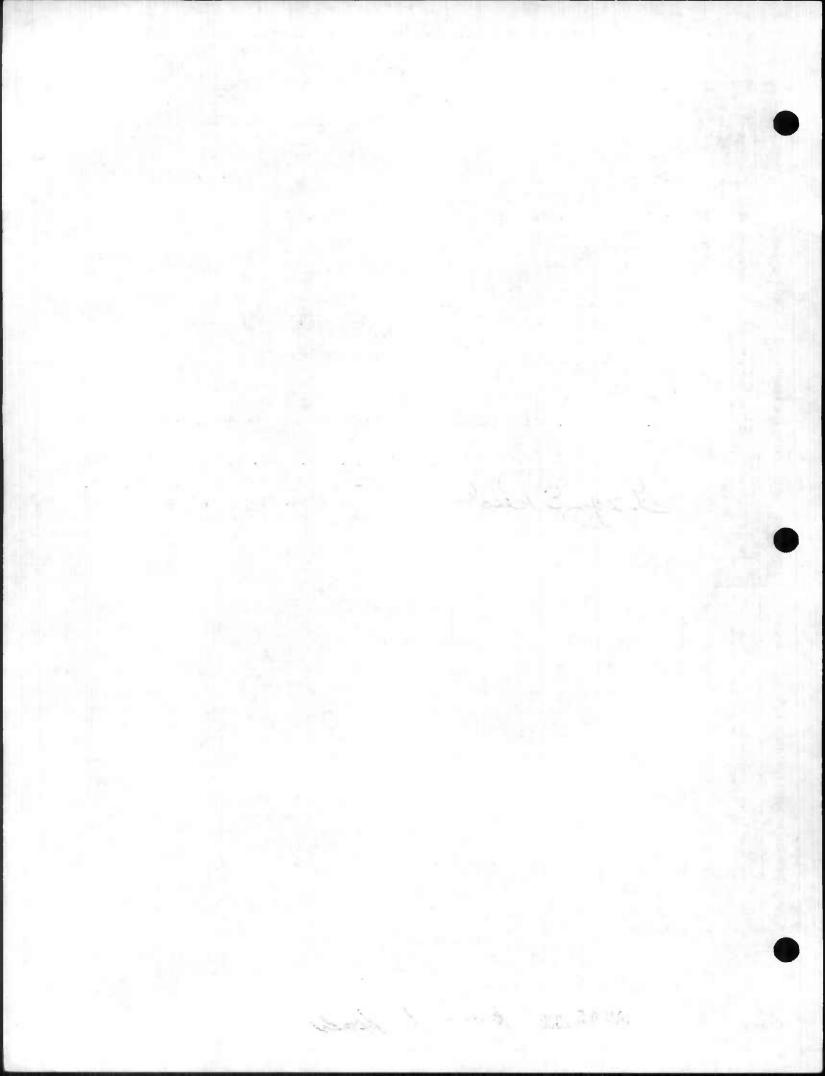
State Registrar

31. Dete filed (Month, Dey, Year)

JAN 0 5 2000

32. Registrer's Signeture

Sparker



Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible.

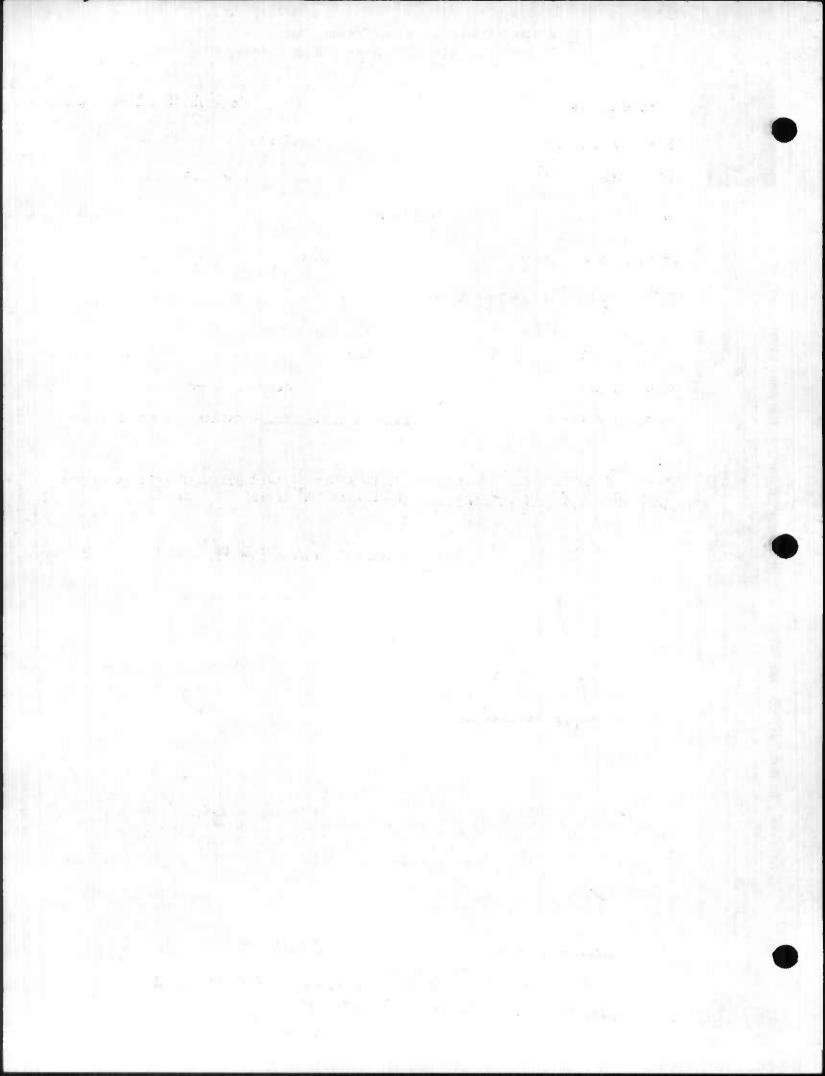
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) December 76, 1999 **Physician** 2:30 PM Richard W. Long /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner N/A Baltimore 15 N. Kresson Street If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 € M 2 □ F Months Days 57 Yrs. Director 218-36-1118 March 15, 1942 SC Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location the Maryla 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No N/A Baltimore MD Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 15 N. Kresson Street Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 12 Yes 2 1 No 1 959
If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 2 should be filed within 72 hours after n and Mental Hygiene. Is marked other than "natural", or its 1 Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) 12 0 home improvements painter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary L. James Homer A. Long 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important. If then 27 is in any injury or other treum 90008. 15 N, Kresson Street Baltimore, MD Mary Brandt/friend 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21 Signature of Funda Jenice Licar Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Pint. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a pick, or heart failure. List only one ceuse on each line. **Physician** Cancer (Non Small cell 2 /2 you /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner the death certificate be executed attending physicien and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760. Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. the 1 les 2 No 3 Probably 4 Unknown signed by hypertension by 3 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? Completed hes 1 Yes 2 No 1 □ Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d, Describe how Injury occurred funeral 28b. Time of Certification: : After 1 i or Attending P s efter death. I Director: After I 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner as steted. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred et the time, date and piece, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 030377 ~ Con 30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print) 98. N. Broadway BALT MB 21231 Robert M. Gooper MN

State Registrar 31. Date filed (Month, Day, Year)

JAN 0 5 2000

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day HELEN **Physician** LAWLESS 11:36am December 29,1999 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GIEN BURNIE AACOUN ARUNDEL YORTH If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Aug 7, 1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country)
 NTSZ **Funeral** Months 1□M 20 F Days Hours 218-26-6381 Director Usual Residence of Decedant 10a. State 10c. City, Town or Location 10b. County 10d. Insida City Limits 312 MILTON AVE. GEN BURNE, ANNE ARUNDEL Be Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? MILTON 312 21061 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) Was Decedent Evar in U,S. Armed Forcas? Race - American Indian, Bleck, Whita, etc. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 Yas 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Ellen Dolan Patrick Crimmins 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 Milton Avenue Glen Burnie, MD 21061 19a. Informant's Name/Relationship (Type, Print) Howard Lawless/spouse 20a. Method of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from State 4 Donation - 6 Other (Specify) 21. Signature of Fungala Service Licenses de . 3thaten And this colloard 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, affect, or heart tailura. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** ACUTE RESPIRATORY FAILURE Immediata Cause (Final diseasa or condition resulting in death) /Medical 3 HOURS Examiner EMPHYSEM A Physician/Medical Examiner MANY YEARS ate has been signed by the attending physician and page 2 should be detached for use as the burish-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiata causa. Entar Undarfying Cause (Diseese or Injury that initiated events rasulting in death) Last Box 68760. Dua to (or as a consequence of): P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 12 Yes 2 No 3 Probably 4 Unknown à Division of Vital Records, 24b. Wara autopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy performed? this certificate has 1 Yas 2 No 1 ☐ Yas 2 2 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Was casa raferred to medical exeminar? Certification: To Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of tnjury 28c. tnjury at Work? 28d. Dascribe how injury occurred 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of tnjury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only 29b. Signature and title of certifig 29c. License number 29d. Data signed (Month, Day, Year) 30. Nama and address of person with d causa of death (Item 23a) (Type, Print) CRAIN HWY GLEN BURNIE ME CARLOS D. 2166 #106 1406 SOUTH

DHMH 16 Rev 6/95

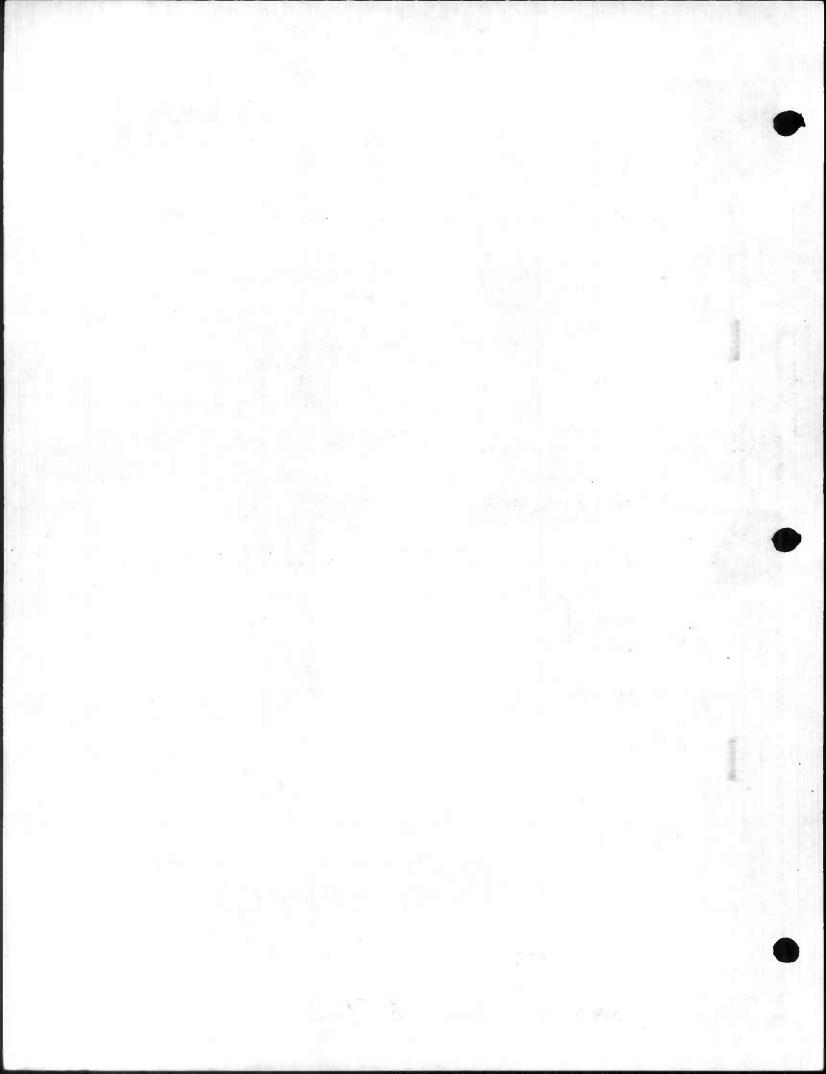
State

Registrar

31. Data filed (Month, Day, Year)

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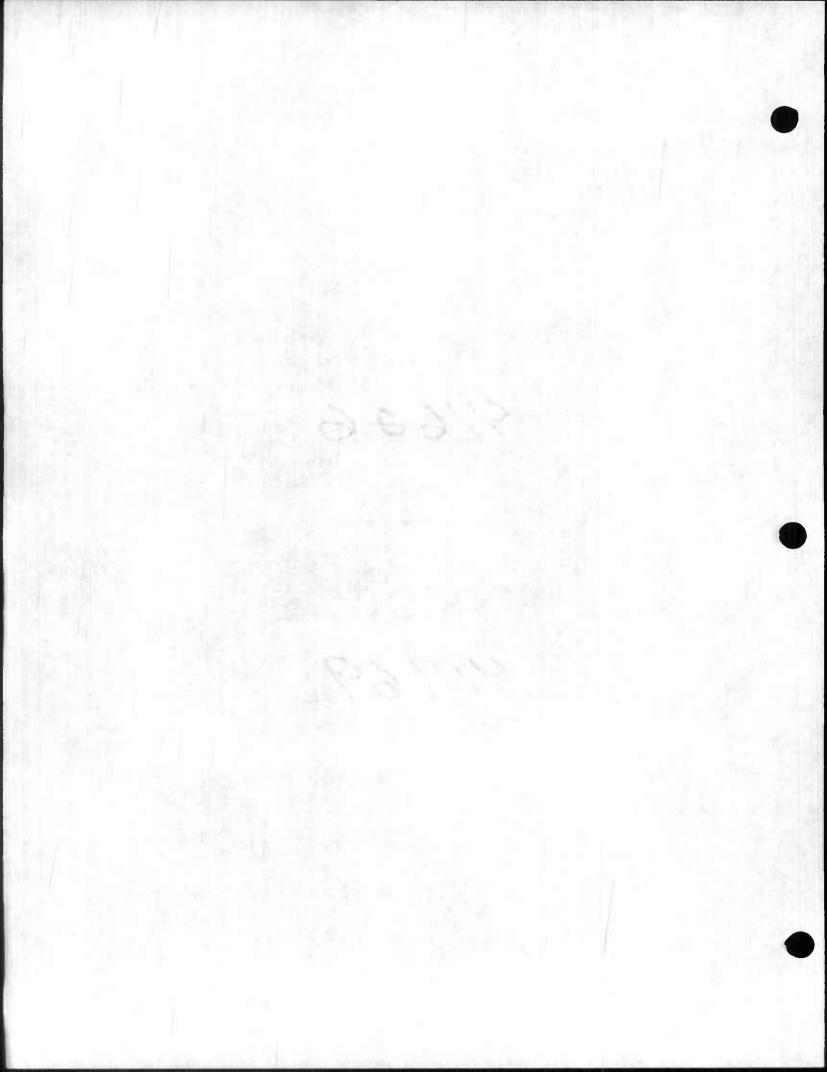
32. Registrar's Signatura



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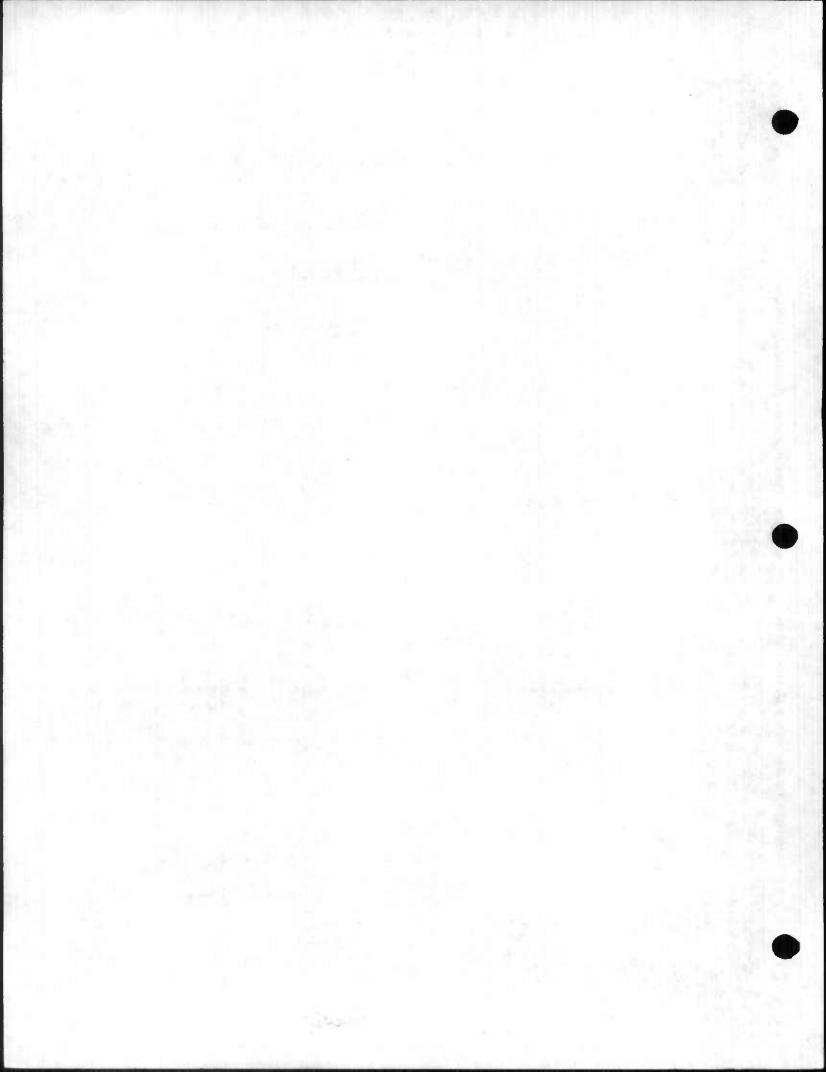
99-7923-510

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AMO	S HOLS		END ITEMS: #23	State of Marylan						4	627	
	Physiciar /Medica Examine	n il	Decedent's Name (First, Middle, Last) A M D S As Facility Name (If not institution, give state)	EDWARD	NICHO			2. Date of Death Month DECEMBER .ocation of Death	Day \	9 12	Time of Death 2:53P.M.	
	uneral lirector	4	1513 ARGYLE AVE 5. Social Security Number 6. Sex	7. Age (In yrs.	(Ast birthdey) If Under Months	r 1 Year Days	If Under 24 Hrs.	8. Date of Birth (Month, Dey, APRIL 03	Year) 5, 1956	9. Birthplace Country)	(State or Foreign	
.0020 hours after death with the Meryland	23a or 28a-f ehow		10a. State 10b. County MARYLAND No. Street and Number	10c. Cit		2 T /	HORE		g. Citizen of Wh	1	Inside City Limits	
er death with	hems 23a or free must be	2	2523 LIN 11. Marital Status	NOEN AVENUE 12. Was Decedent Ever in U.S. 13. Was Deceder			2/2/ Hispanic Origin? (Sl an, Mexican, Puent	7 pecify Yes or No-	USA			
5 0	- 1	2	15. Decedent's Edur (Specify only highest grade	1 Yes 2 No If Yes, Give Year or Dates:	16a Decedent's Usi	1 ☐ Yes 2 ☑ Alo Specify: 16a. Decedent's Usuat Occupation (Give kind of work done during most of work life. DO NOT use retired)			Specify: 6b. Kind of Busi	BLF iness/Industr	7CK	
	ont, the Man	pe completed	Flementary/Secondary (0-12) 4 H GRADE 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life. DO NOT	use retire	BOY	ne (First, Middle, M		URA	NT	
	7 is marked of treumatic ev	0	AMOS EDWA 19e. Informant's Name/Reletionship (Ty)		19b. Mailing Addres	s (Stree)	1				
	ant: If item 27		20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)		Place of Disposition (Na	other pla	RESTON ORV	Date /2	0c. Location - C	ity or Town,		
Balt Permit.	importanti any injury once.		21. Stronture of Funeral Service Lognar	ms)	014	ON	ORY ess of Facility H. B. FULTE	N HUE.	DALTI	YORK A	76 HOME 10.21217 proximate	
<i>i /N</i>	ysician ledical aminer		Enter the disease, or compliance or heart feiture. List only or Immediate Cause (Final disease or condition resulting in death)	LI	VER CIRRI	HOSI				Inte	erval Between set and Death	
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ords,	Pe d	2					elim.	24e. Wes er perform		availat	autopsy findings ble prior to elion of cause th?	
= F	# o	se completed	25. Was case referred to medicat examiner?				26. Place of Dea	15 Ye			es 2 No	
O A	After this c funeral dire	2	27. Manner of Death 1 1 Natural 5 Pending 2 Accident investigation	dospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Inju		lome 5 Reside 28d. Describe ho			SCENE	
S 8	i de		3 Suicide 4 Homlcide 6 Could not be determined	28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)				28f. Location (Street end Number or Rure! Route Number, City or Town, State)				
To the Hospital	o the Funer ampletely file	medica	29a. Certifier (Check only one) 1 Certifying Physical Medical Examination 2 Medical Examination of Certifier	nician: To the best of my kno ner: On the basis of examina and manney stated.	tion and/or investigatio	n, in my	opinion, deeth occu	rred at the time, da	use(s) and men ite and place, ar	nd due to the	cause(s)	
٩	8 4		1	966			.C.M.E.		NUARY 1			
(X.		30. Name and address of person who co	mer	111 I	Penn	Street,	Baltimore	e, Maryl	and 2	1201	
	State Registrai	-	31. Date filed (Month, Day, Year) JAN 0 5 200	32. Registrar's Signa		000	61					

DHMH 16 Rev 6/95

ORIGINAL



Physician

/Medical Examiner

anding physician and use as the buriel-transit

ate has been algned by the attending page 2 should be detached for use as

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

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Completed

Medical Certification: To Be

4 Homicide

B.K.S WAYNE F. 1				of Marylai	nd / Dep	artmen	t of I		and I			9	41628
Physician /Medical	W 237m2	CM. CHIPETTE	er Norton							2. Date of D Month DEC.	Day 18, 19	Year 99	3. Time of Death
Examiner		(If not institution HIGHPOIN	n, give street and no TT ROAD	umber)				4b. City, To FORE		ocation of Dea		ty of Death FORD	
Funeral Director	5. Social Security unknown		6. Sex 1 M M 2 □ F	7. Age (In yrs	. last birthday 47 Yrs.	Months			24 Hrs. Min.	8. Date of B (Month, D May 11	av. Year)	9. Birth	place (State or Foreig intry) unknown
Maryland and an arrange at above	Usual Residence 10a. State MD	10b. County	Harford		ity, Town or L							10d. Inside City Limits 1 ☐ Yes 2 No	
uth with the Maryler 23s or 28e-f show as the notified at	10e. Street and N 1816 Hi					10f. Zip		21050			10g. Citizen of US		intry?
020 un effer des alt, or flems teamber in	3 ☐ Widowed	unknowi nried 2 Marri 4 Divorced	Armed F	cedent Ever in torces? 2 No live DatesUnkno		Was Deced If Yes, special 1 Yes				pecify Yes or No Rican, etc.)	lo- 14. Ra Bi Spec	ack, White	ican Indian, , etc. white
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D STORE OF S	17. Father's Nam		Last)					18. Moth		ne (First, Middl nown	e, Maiden Suma	ume)	
_ c=n_		Name/Relationsl	nip (Type, Print)			ing Address Penn				ral Route Num timore	ber, City or Tow MD 212		ip Code)
more seges and seges	20a. Method of D 1 Burial 4 Donation	2 Cremetion	3 □Removal from pecify) in Si	State	Place of Disp cemetery, cre	metory or o	ther pla		1	Date	20c. Location		
Baitir permit. P Department important eny injur		Funeral Segrices	icenseade, I	Directo:	,	3. Warteer Baltin			Boar 212		V. Balti	more	Street

21201 Baltimore, MD 23a. Part1. Enter the disease, or com shock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death?

Probably 4 Unknown 1 ☐ Yes 2 ☐ No

24a. Was an autopsy performed?

2 No

24b. Were autopsy findings available prior to completion of cause of death?

18, 1999

Yes 2 No

Approximate Interval Between Onset and Death

25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home MResidence 6 Other (Specify) 1)∑ix es 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA

27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Succident
3 Suicide 5 Pending investiga Victim 199 1 Yes 08

6 Could not be ace of Injury - At home, farm, street, factory, office ilding, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2/050

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Collection Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

**Collection Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E

ited cause of death (Item 23a) (Type, Print)

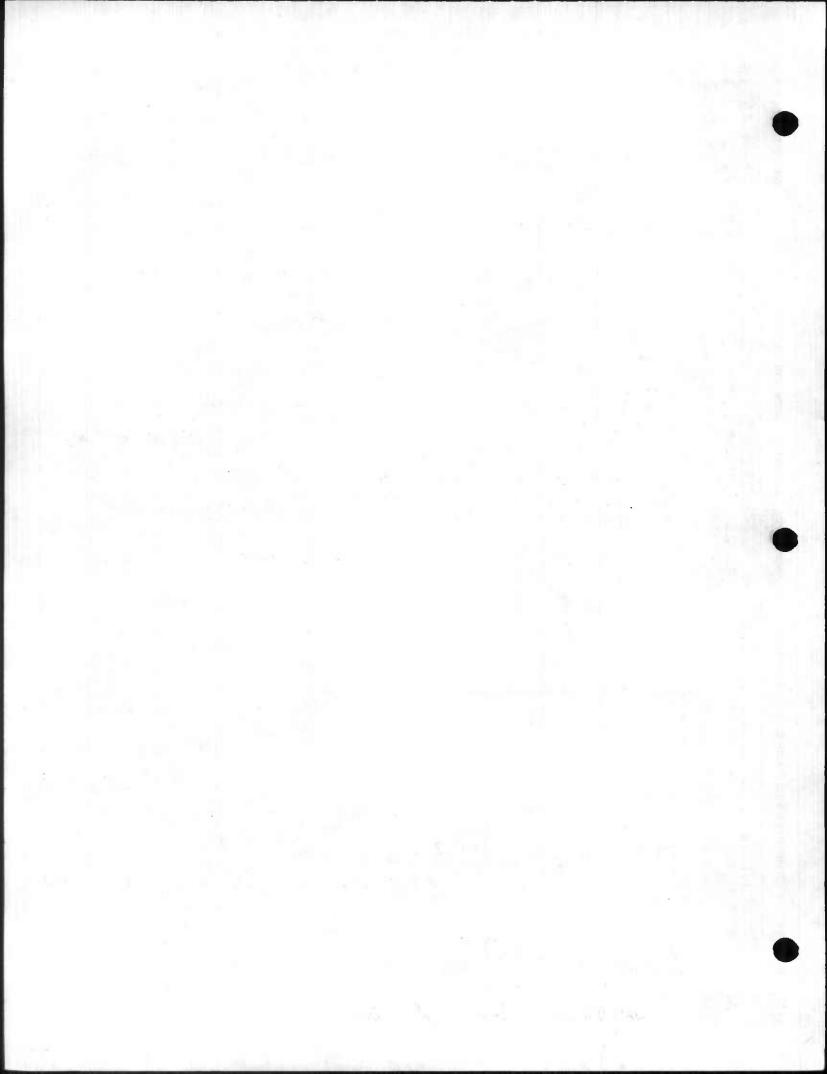
111 Penn Street, Baltimore, Maryland 21201 JAN 0 5 2000 32. Registrar's Signature

State Registrar

DHMH 16 Rev 6/95

within 24 hours after deeth.

To the Funeral Director: After this certified completely filled in by the funeral director. To the Hospital or Attending Physician:



Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

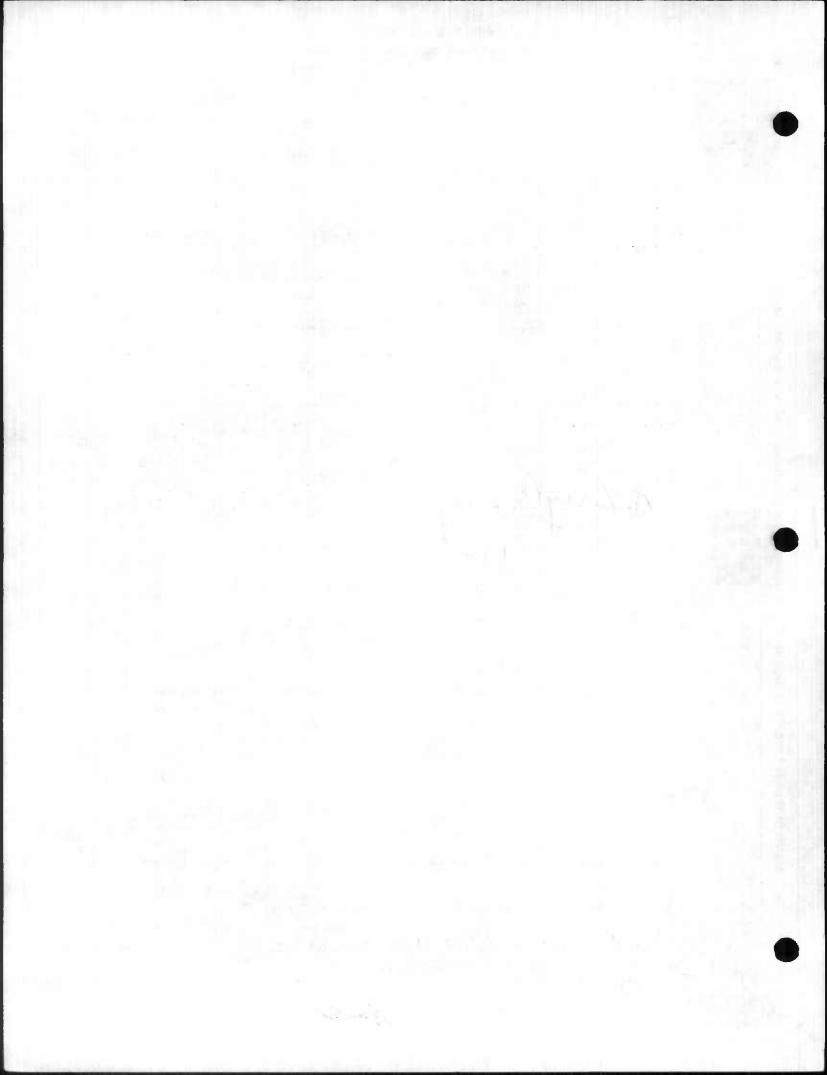
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					Ce	rtificate c	t Deatr	7		Reg. No.		to the st	
1	Physician /Medical	1. Decedent's Name (First, Mi	odle, Last) NAO	MI R	EIER				2. Date of D Month DEC 2	29 1999	Year	3. Time of Death 9:10am	
	Examiner	4a Facility Name (If not institution 1101 Mic							Rive				
	Funeral Director	5. Social Security Number 213–28–9280	6. Sex 1 □ M 2 □ N	7. Age (In yrs.	last birthday) 78 Yrs.	Months Da		r 24 Hrs. Min.	8. Date of B (Month, D Feb. 1	orth (1921)		aca (State or Foreign ry) yland	
	h the Maryland r 28a-f show inotified at frector	Usual Residence of Decedent 10a. State 10b. Cour MD E	altimore	10c. Cit	y, Town or Lo	cation		Midd	le Riv	er	10	od. Inside City Limits	
	\$ 0 P O	10e. Street and Number 1101 Middl	ewav Road	J.		10f. Zip Cod	2122	0		10g. Citizen of		ry?	
020	15-0020 172 hours after 'natural', or the	11. Marital Status 1 Never Married 2 N	12. Was D Armed 1 1 Yes	Decedent Ever in U. I Forces? es 2 DENo		Was Decedent of Yes, specify C	of Hispanic O Juban, Mexica	rigin? (Spe in, Puerto	ecify Yes or N Rican, etc.)	lo- 14. Ra Bla Specit	ca - America ck, White, e		
21215-0		15. Dece (Specify only hig Elementary/Secondary (0-12	lent's Education thest grade complete 2) Colleg	e (1-4or 5+)	(Give	dent's Usual Oc kind of work do DO NOT use re Memaker	cupation ne during mo ired)	st of worki	ing	16b. Kind of B	usiness/indu		
land	poemit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than may injury or other treuments avant, fra Mance. To Be Compi	17. Father's Name (First, Middle unknown	le, Last)				18. Moth	unkn		e, Maiden Surnar	пе)		
5	d N d	19a. Informant's Name/Relation	vachin (Tune Print)		10h Maili	na Addrone (Str	ant and Alumi	har or Dun	al Pouto Num	ber, City or Town	State Zin (Code	
e, Ma	7 2 4 7	Maynard Well		205 8	861	7 Fowle:	Ave.			Md. 2123	34		
Baltimore,	permit, Pages 1 and 2 Department of Health s Important: If Item 27 is any Injury or other tra page.	1 ⊠ Burial 2 □ Crematic 4 □ Donation 5 □ Other		om State		sition (Name of natory or other ill Ceme		1/3/			imore		
Balt	Departi Departi Import any Inj pnca	21. Signature of Funeral Servi	ce Licensee	10	22		ly Fun	eral		of Essex			
Box 68760,	X & E . 2	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	b	DIABET	or as a consec Or as a consec	juence of): ATER: juence of): MEL!			EDDE			Onset and Death	
P.O.	that the death coned by the attence detached for us	Part II. Other significant cond	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part							23b. Did tobacco use contribute to the cause			
Division of Vital Records,	aw requires as been sign 2 should be									s an autopsy formed?	avai	re autopsy findings ilable prior to apletion of cause leath?	
=	The page								10	Yes 2 No	10	Yes 2□ No	
±	Physician: The this certificate ral director, page Co	25. Was case referred to medi examiner?	cal				26. Plac	e of Deat	(Check only	one)			
>	nis ce l'dire	1 Yes 2 No	Hospital: 1	☐ Inpatient 2☐	ER/Outpatier	nt 3 DOA	Other: 4 N	lursina Ho	me 5 12 Res	sidenca 6 Ott	her (Specify)	
ion of	Attanding Physician: The I erdocath. erdocath. erdocath. by the funeral director, page by the funeral To Be Com	27. Manner of Death 1 Matural 5 Pen 2 Accident inve	28a. De	ote of Injury fonth, Day Year)	28b. Tima o Injury	28c. l	njury at Vork?			how injury occu			
Divis	XESC L	3 Suicide 6 Cou	mined 200, Pi						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
	n 24 hour n 24 hour ne Funer piataly fill edical	29a. Certifier 1 Certification (Check only one)	ying Physician: To al Examiner: On the and m	the best of my kno- e basis of examinal anner stated.	wledge, death tion and/or in	occurred at the restigation, in m	time, date a y opinion, de	nd place, ath occurr	and due to the	e cause(s) and m e, date and place,	anner as sta and due to	ited. the cause(s)	
	To the Company of the	29b. Signature and title of certi	nustela	Oarm'	MO		ense number	-2		29d. Date signe		(999)	
	7		N. QA	RNI/M		Print) 1224	CHE	SA	co F	TUE, BA	CTO, M.	D21237	
	State	31. Date filed (Month, Day, Ye	nr) 32	. Registrar's Signa	iture	,							

QHMH 16 Rev 6/95

Registrar

JAN 0 5 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death REUWER DECEMBER 30, 1998 1745 HO BARBARA 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death RANDALLSTONN BALTIMORE NORTH WEST HOSPITAL If Under 1 Year | If Under 24 Hrs. | 7. Age (In yrs. last birthday). 8. Dete of Birth 9. Birthplace (State or Foreign Country) Sept. 22, 1924 Maryland 5. Social Security Number Months Days Hours 1□M 20 F 216-20-2070 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md. Baltimore Owings Mills 10a Street and Number 10f. Zip Code 10g, Citizen of What Country? 10 Sierra Cir. Apt. K 21117 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2200 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Statue 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White 30Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Thomas Connelly Unknown 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Bruce Reuwer 10 Sierra Cir. Apt. K, Owings Mills, Md. 21117 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Jan. 4, 2000 Baltimore, Md. 22. Name and Address of Facility 21. Signature of Funeral Service License Eckhardt Funeral Chapel 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, as a cardiac or respiratory arres GASTROINTESTINAL BLEED Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 1 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

ahoa a

r 25a-f

b

"natural", or litera 23a

permit. Pages 1 and 2 should be flied within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Examines

Maryland 21215-0020

Saltimore,

DOX 68760.

P.O.

Records,

Division of Vitai

Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica

To the Hosp within 24 hou To the Fune completely fi

funeral

filled in by

Director

Funeral

þ

Completed

Be

the Maryland

Examiner

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certified

31. Date filed (Month, Day, Year) JAN 0 5 2000

Physician/Medicai Completed Be Medical Certification: To 27. Manner of Death

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last SIADH. 25. Was case reterred to medical

5 Pending investigefion

6 Could not be determined

LUNG MASS 26. Place of Deeth (Check only one) 1 Yes 2 No

1 Anpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dev Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

24a. Was an autopsy performed?

1 ☐ Yes

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted.

2 No

29c. License number D37333 29d. Date signed (Month, Day, Year) DECEMBER 30, 1999

24b. Were autopsy tindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

RALTO. UP MD, NHC. NAUI

Registrar

32. Registrar's Signature

The series of th

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

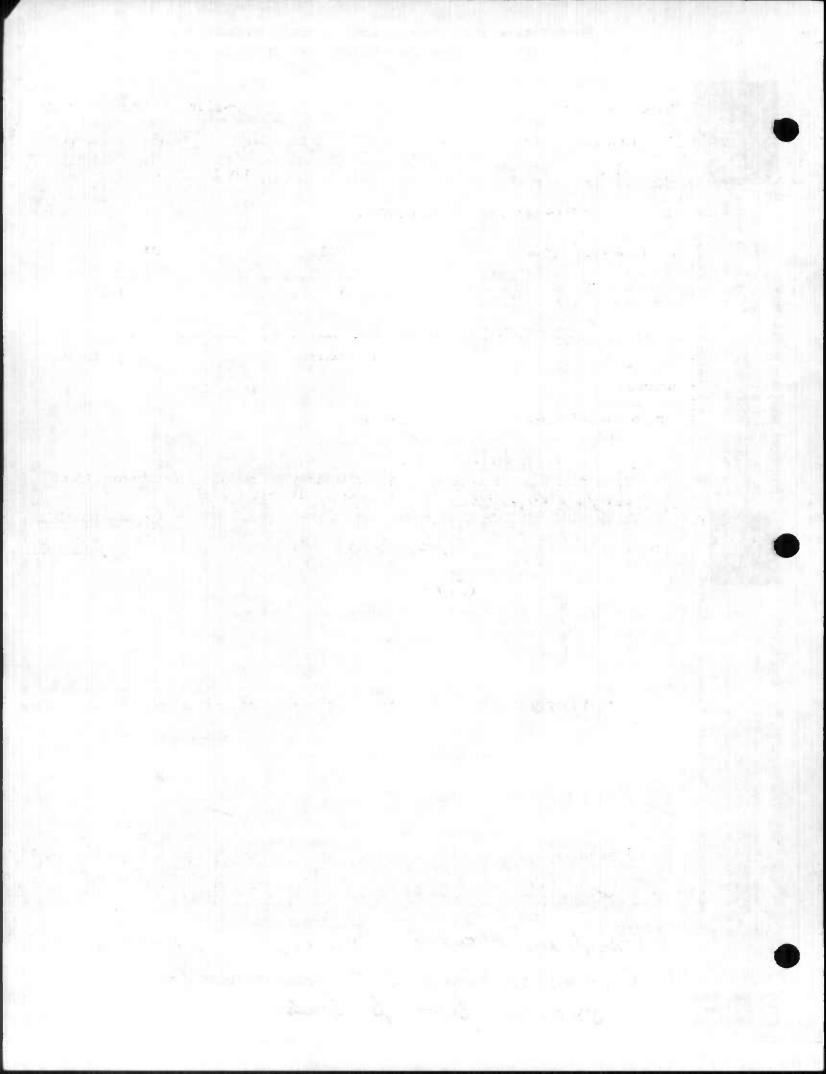
State of Maryland / Department of Health and Mental Hygiene 9 4 63 Certificate of Death 2. Data of Deeth 3. Time of Deeth 1 Decedent's Nama (First Middle Last) **Physician** 13, 1999 December 7:27 AM Robert Reinhardt /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince Georges 3905 Lakehouse Drive Beltsville | H Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Devs | Hours | Min. | (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2□ F Yrs. Aug 16, 1926 MD Director 212-22-1956 Usuel Residence of Dacedant the Meryland 10a. Stete 10b. County 10c, City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23s or 28s4 show other traumatic event, fre Medical Examinar must be notified at MD Prince Georges Beltsville 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizan of What Country? with t 20705 3905 Lakehouse Drive USA Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Medtel Status parmit. Pages 1 end 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examines XYes 2 □ No fYas, Give Yeer or Dates: 1 Naver Married 2 Marriad 1 Yas 2 No white Baltimore, Maryland 21215-0020 Specify: by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elamantary/Secondery (0-12) 12 0 bus driver transportation 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) unknown Helen Kaye 19b. Malling Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Coda) 19e. Informent's Name/Relationship (Type, Print) Janice Brown/friend unknown 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Mathod of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from Stata 4 □ Donetion 5 ☒ Other (Specify) in state 21. Signature of Ronald Section Wade, Director 23 Partend Affactomy Board 655 W. Baltimore Street 21201 Baltimore, MD Part 1. Entar the disease, or complications that caused the death. Do not antar tha mode of dying, such as cerdiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Physician Hupoxia. immediete Ceuse (Finel diseesa or condition resulting in daeth) /Medical FRED HRS. Examiner Due to (or es a consequence of): Examiner CHE ettending physician end for use es the buriel-transit Sequantially list conditions, if eny, laading to immediata ceuse. Enter Underlying Cause (Disease or injury Due to (or es e consequance of): certificate be execu Box 68760 Physician/Medical thet initieted events resulting in death) Last Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown HTN. Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performad? Completed 1 ☐ Yes 2 ☐ No Be 25. Wes cese rafarred to medical 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Home \5 ☐ Hesidence 6 ☐ Other (Specify) Yes 2 No P After this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Tima of 28c. Injury et Work? Certification: Naturel 5 Panding investigation 1 Yes 2 No death. Hospital or Attendi
 24 hours after death
 Funeral Director: A 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Plece of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicida McCertifying Physician: To the best of my knowladga, daath occurred et the time, dete end piece, and dua to the ceuse(s) end mennar as statad.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred et tha time, date end piace, and dua to the ceuse(s) end menner stated. 29a. Certifier edicai To the Hosp within 24 hou To the Fune completely fi (Check only one) 29d. Data signed (Month, Dey, Year) 29b. Signature and titla of certifier 29c. License number Allendrug Structe MD 12-26-99 30. Nama end eddress of person who completed ceusa of deeth (Item 23e) (Type-Print) #13 BLADENS BURY M3 20710.

State Registrar 31. Dete filed (Month, Dey, Year)

32. Registrer's Signeture

JAN 052000 >



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Months

7. Age (In yrs. lest birthday)

Yrs.

10c. City, Town or Location

82

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Day Year Month 50 stoke 12 99 30 02

If Under 1 Year | If Under 24 Hrs.

Hours

Deys

Physician	
/Medical	
Examiner	

Edna

5. Social Security Number

10a State

Director

Funeral

ρ

MD

11. Marital Status

10e. Street and Number

212-28-3847

Usual Residence of Decedent

4a Fecility Neme (If not institution, give street end number)

6. Sex

1□ M 2□ F

BonSecour Hospital

10b. County

5719 Nasco Place

1 ☐ Never Married 2 ☐ Married

X Widowed 4 □ Divorced

NA

15. Decedent's Education (Specify only highest grade completed)

Funeral Director

the Maryla. r than "natural", or items 23s or the Medical Examiner must be r Hygions.

72 hours after filled within and Mental Hygis is marked other benit. Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 is marked o 8

Completed Elementery/Secondery (0-12) 12th Grade College (1-4or 5+) NA Home maker 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) James Banks Lucy Green 19a. Informent's Name/Relationship (Type, Print) Evelyn Wiley Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 01-07-99 Baltimore, MD 21. Signatury of Funeral Service Liethsee 22. Name and Address of Facility Part 1. Enter the disease, or complications that caused to shock, or heert failure. List only one cause on each line. aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Physician** /Medical Immediate Cause (Finel Seps.3 disease or condition resulting in death) Examiner Due to (or as e consequence of): Physician/Medical Examiner that the death certificate be executed Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Bud ettending physicien for use as the buriel perpheral Box 68760 variale dx Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. the signed by t Records, þ Completed peed Wel hes The 1 TYPS 2 TING certificete Division of Vital or Attending Physician: efter death. 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No this funeral 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28h Time of Certification: After 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No n 24 hours efter death.

He Funeral Director: All pletely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stefe) 28e. Pleca of tnjury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and pieca, end due to the ceuse(s) and manner stated. To the P within 2 To the F 29b. Signature and title of cartifier 29c. License number 031865 m.a -0 30. Name and address of person who complete fause of death (Item 23e) (Type, Print) Entan street Mion - O Kidung 821 N 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 5 2000 Registrar

towes 2 □ No Baltimore 10f. Zip Code 10g. Citizen of What Country?

8. Dete of Birth (Month, Day, Year)

09-27-17

4c. County of Death

16b. Kind of Business/Industry

Birthplece (State or Foreign Country)
 VA

10d. Inside City Limits

USA 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

4b. City. Town, or Location of Deeth

Baltimore

Min

14. Raca - American Indien Black, White, etc. 1 ☐ Yes 2 No Specity: Specify: Black

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ZZNo If Yes, Give Year or Detes: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

in & out of home

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 02118

599 Columbus Avenue Boston, Massachussetts 20c. Location - City or Town, Stete

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue Approximete Interval Between Onset and Death

Severe a theroscleration cardiovascular dx

23b. Did tobacco use contribute to the causa of death? 1 Yee 2 No 3 Probably 4 donknown

24a. Was en autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

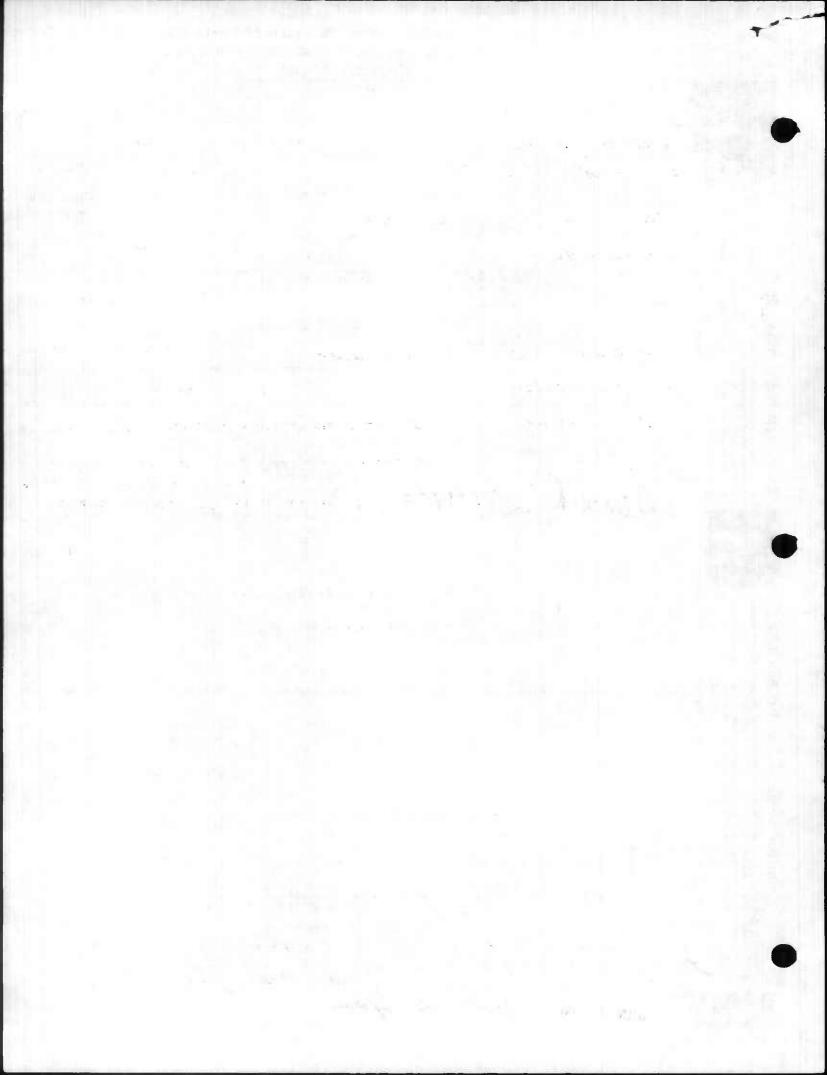
1 □ Yes 2 → No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

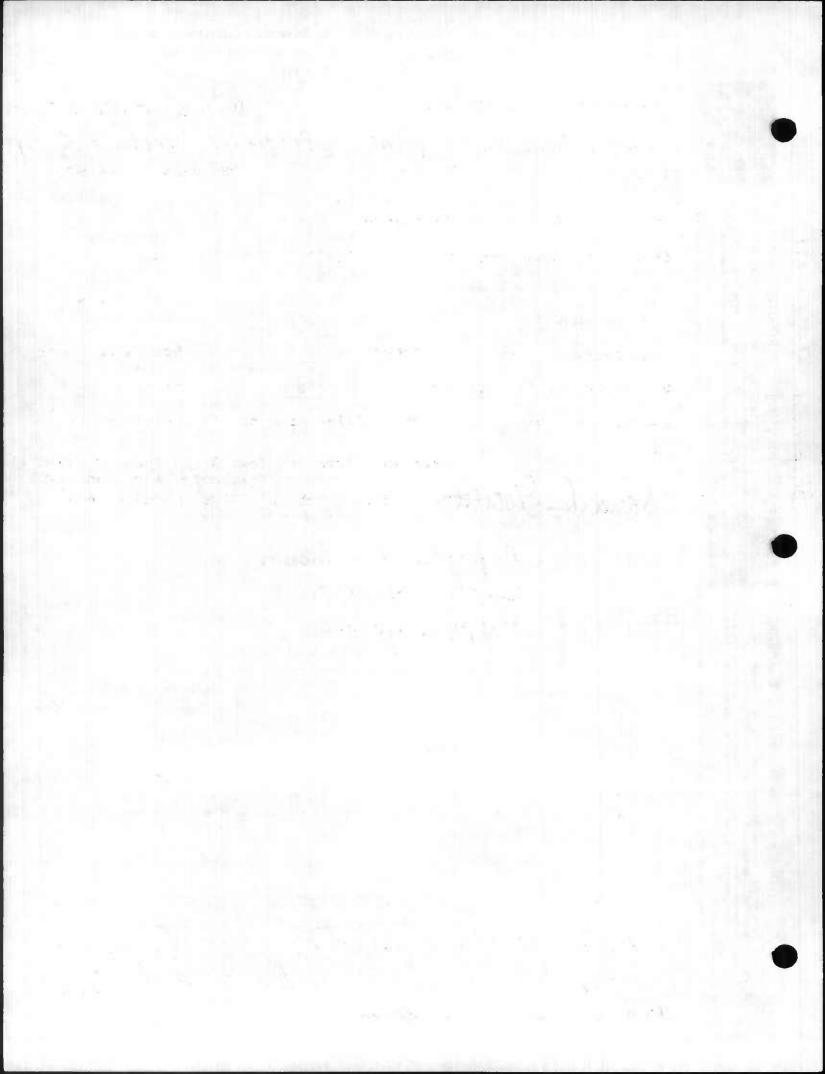
1 🗹 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the ceuse(s) and manner as steted.

29d. Date signed (Month, Dey, Year)



Shipman, Acosevelt Baltimore, Maryland 21215-0020

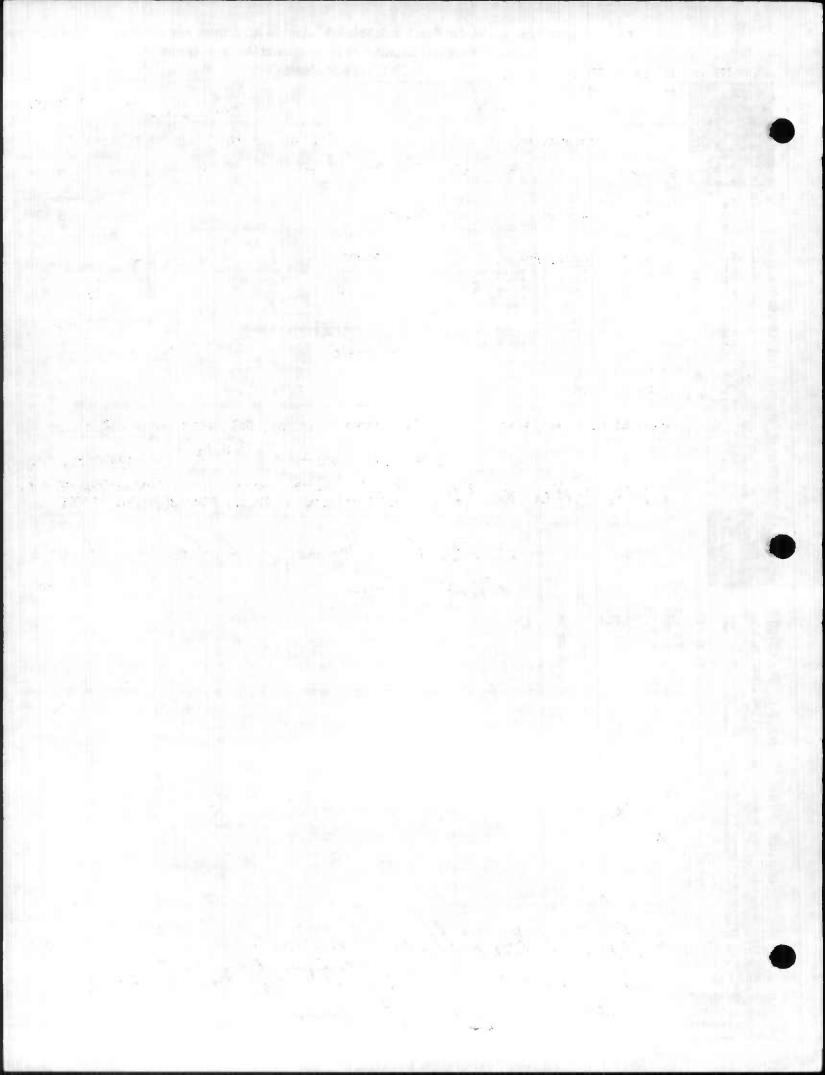
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Physician	Roosevelt Shipm	an	Month	1 Day 29 Yeer 29 1:30		
/Medical Examiner	4a Facility Name (If not institution, give street and number)		b. City, Town, or Location of Dea	th 4c. County of Death		
uneral	104 105 50	S Di ta L s. las birthday) If Under 1 Year Yrs. Months Days	BACTIMOVE If Under 24 Hrs. Hours Min. 8. Date of Bi (Month, D 08-1	BALTIMORE CIT 9. Birthplace (State or Foreign 8-26 NC		
ector	243-30-4981 XM ZUF /3 Usual Residence of Decedent		00-1	8-20 NC		
or sedan		city, Town or Location		10d. Insida City Limi		
at be notified at	MD NA B	altimore		XX Yas 2 N		
Sire.	10e. Street end Number	10f. Zip Code		10g. Citizen of What Country?		
Tal le	5803 Hillen Road Apt. "B"	2123		USA		
finer must be notified Funeral Director	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Specify Yes or N In, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indien, Bleck, White, etc.		
by	1 □ Never Married 2 Married 1 □ Yas 2 □ No If Yes, Giva Yaar or Dates:	1 ☐ Yes 2 ☐ No	Specify:	Specify: Black		
lete	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired	etion during most of working	16b. Kind of Business/Industry		
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even Be	17. Father's Name (First, Middle, Last)		18. Mother's Neme (First, Middle			
eumetic event, To Be Co	Roosevelt V. Shipman, S 19a. Informent's Name/Relationship (Type, Print)	10h Mailing Address (Street	Eva	Newkirk ber, City or Town, State, Zip Code) 2122		
	Delores Shipman			ber, City or Town, State, Zip Code) 2123 "Baltimore, MD.		
any Injury or other treumstic event, once. To Be C		Place of Disposition (Neme of	Date	20c. Location - City or Town, Stata MD		
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Injury B.	21. Signatura of Funeral Service Chenses	22. Nama and Addres		+06-2000 Owings Mi re, Maryland 21202		
any l	Man mal Harton			. North Avenue		
	23a. Penti. Buter the disease, or complications that caused the dec shock, or heart failure. List only one cause on each line.					
ing physician and in	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or es a consequence of): Shock (or es a consequence of): Gores a consequence of):	nonia			
ed for use e	Part II. Other significent conditions contributing to death but not re	esulting in the underlying cause giv	en in Part I. 23b. Dic	d tobacco use contributa to the cause of deat		
detached			1	Yes 2 No 3 Probably 4 Unkno		
cata has been signed by the attending physic, page 2 should be detached for use es the by completed by Physician/Medical			24e. Wa	s an eutopsy formed? 24b. Were autopsy tindings evailable prior to completion of cause of deeth?		
age 2			1□	Yes 22 No 1 Yes 2 No		
rector, pag	25. Was case referred to medical		26. Piece of Death (Check only			
9	examiner? 1 Yes 2 No Hospital: 1 Impatient 2	□ ER/Outpatient 3□ DOA Oth	Or.	sidence 6 Other (Specify)		
Completely filled in by the funeral displays Medical Certification: To	27. Menner of Death 1 Naturel 5 Pending 2 Accident Investigation 28e. Date of Injury (Month, Dey Year)	28b. Time of Injury Wor M	y et k? Yes 2 □ No	how injury occurred		
mpletaly filled in by the funera Medical Certification:	3 ☐ Suicide 4 ☐ Homlcide 6 ☐ Could not be determined 28e. Plece of Injury - At building, etc. (Special Coulding)	28f. Location City or To	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)			
staly fille	29a. Certifier (Check only one) 1 Certifying Phyaician: To the best of my km and manner steted.					
2 6	29b. Signatura and title of certifier	29c. Licens	a number	29d. Dete signed (Month, Dey, Year)		
E 2			10000	1 - 1		
₩ 2	Donatun M Mace	m mo n	15 502	12/20/00		
NOO X	Donatun M Mace	m mD D	15503	12/30/99		
N N	30. Name and address of person who completed cause of deeth (Ite AMATI) IN MART	om 23e) (Type, Print)	olahin st	B-1/2 MD 17		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

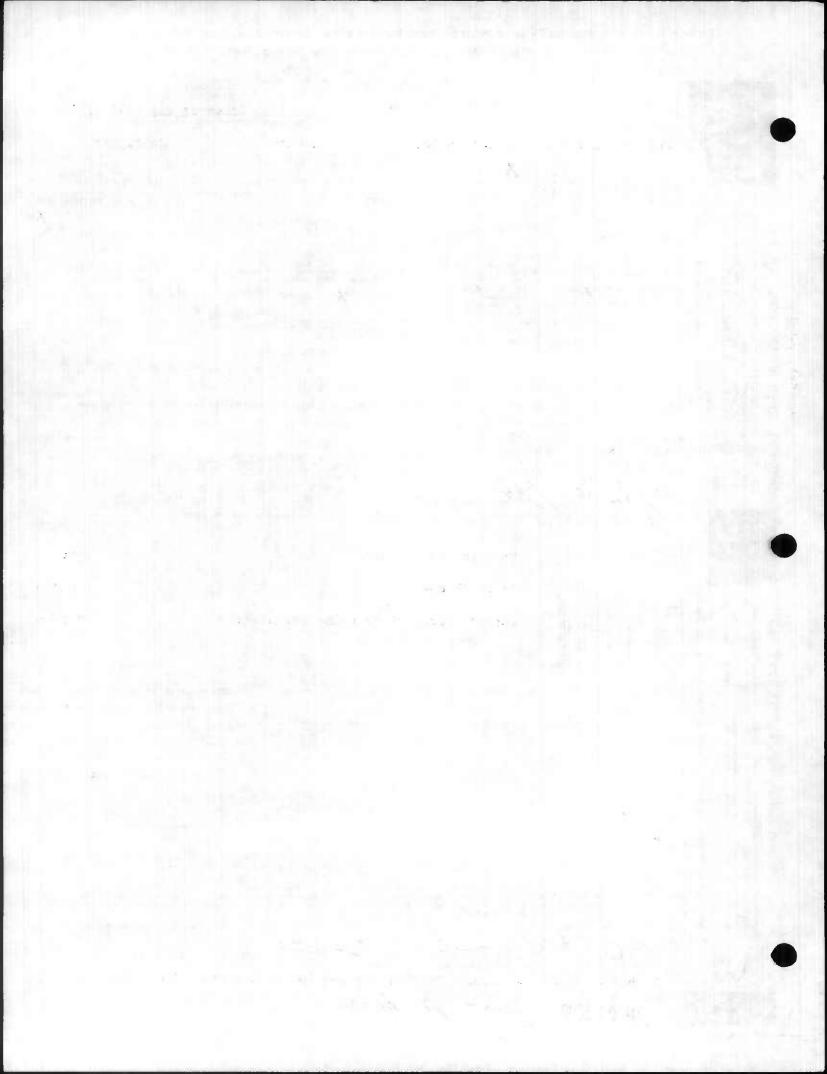
AMEND ITEMS:	# 26 PER MD G779 1-5-2000 WR. Certificate of De		41634
Physician	1. Decedent's Neme (First, Middle, Last) Marilie Seese	2. Dete of Deeth Month Dey Year Dec. 27, 1999	3. Time of Death 2:15 PM
/Medical Examiner	4e Facility Neme (If not institution, give street end number) 4b. (City, Town, or Location of Deeth 4c. County of Dee	
Funeral Director	5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Yeer If	timore Highlands Baltim funder 24 Hrs. B. Dete of Birth Hours Min. JUNE 15, 1935 Wes	nore hthplaca (State or Foreign country) st Virginia
the Maryland 28a-f show notified at	10a. State 10b. County 10c. City, Town or Location MD Baltimore Lansdowne		10d. Inside City Limits 1 ☐ Yes 2 ② No
the Maryla 28a-f sho notified	10e. Street and Number 10f. Zip Code	10g. Citizen of Whet Co	,,
23a or	200 First Ave., Apt. 119 21227	USA	
020 urs after dea ut; or flems	11. Maritel Status 12. Wes Decedent Ever in U, S. Armed Forces (A) 1 □ Naver Married 2 □ Married 1 □ Yas 2 □ (No)	enic Origin? (Specify Yes or No- Mexican, Puerto Ricen, etc.) 14. Rece - Ame Bleck, White	
nd 21215-0020 se filed within 72 hours af all Hygiens all Hygiens, or vent, the Medical Exam Be Completed by F	15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Waitress	on 16b. Kind of Business ing most of working Restaura	
nd of filed all Hyg		B. Mothar's Neme (First, Middle, Meiden Sumeme)	
ryla hould the marked marked To	Ira E. Woods 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end	Clara L. Pugh d Number or Rural Route Number, City or Town, Stete,	Zin Codel
Ma nd 2 si alth an 27 is r			222
Baltimore, Maryland 2121 permit. Peges 1 end 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is mented other than any injury or other traumetic event, the He pace. To Be Compl	20e. Method of Disposition 1 National Survivation 1 Department 1 Department	12/30/00 20c. Location - City or	
Balt Permit. Departr Importa			
Physician /Medical	23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, s shock, or heart failure. List only one cause on each line.	such es cerdiac or respiretory errest,	Approximete Intervel Between Onset end Deeth
Examiner	Immediate Ceuse (Finel disease or condition rasulting in death) e. Bladder Corner Meta. Dua to (or as a consequence of):	istatic to bone	1 C 2
P.O. Box 68760, that the death certificate be executed as by the attending physician and deteched for use as the buriet-trensit Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate causa. Entar Underlying Causa. (Disaese or injury that initiated evants resulting in deeth) Lest Due to (or es e consequence of): Due to (or es e consequence of):		70 70.
O. B. ie death the atte hed for	Pert II. Other significant conditions contributing to death but not resulting in the underlying couse given it	in Pert I. 23b. Dld tobacco use contribut	ta to the cause of death?
IS, P.O. Box se that the death certigened by the attending be deteched for use a by Physician/M		1 Yes 2 No 3 F	Probably 4 Unknown
Record s law requir has been s je 2 should		performed?	Were eutopsy findings eveilable prior to completion of cause of deeth?
f Vital Fysician: The ysician: The director, pag	25. Was cese referred to medical 26	1 ☐ Yes 2 D(No	1 Yes 2 No
On of sing Phys	27. Menner of Daath 1. Neturel 5 Pending 2 Accident invastigation 3 Sujeide 6 Could not be	A Nursing Home 5 Residence 6 Othar (Spet) 28d. Dascroe how injury occurred \$ 2 \sum No 28f. Location (Street end Number or R	
Div Ital or A Iris effer is al Direct Ited in by	4 Homicida determined building, etc. (Specify)	City or Town, State)	
Division To the Hospital or Attention within 24 hours efter death To the Funeral Director: completely filled in by the Medical Certifical	29a. Cartifier (Check only one) Certifying Phyaician: To the bast of my knowledge, death occurred at the time, the ical Examiner: On the bast of axamination and/or investigation, in my opinion of the control of the ical Examiner: On the bast of my knowledge, death occurred at the time, the ical Examiner: On the bast of my knowledge, death occurred at the time, one)		
To within Common Common Williams	29b. Signature and topolot certifier Collaboration D 29c. License no.	Y356 Dec.	28, 1999
0	30. Name and address of person who completed county from 23a) (Type, Print) S.F. 45.	Au Balt Mil 212	rig
State Registrar	JAN 05 2000 32. Registrar's Signature	2	

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 41635

				Certifica	ite of	Death		Reg	. No.			
Physician (Madical	Decedent's Nama (First, Middle,		arie Sout	her			Mo	ta of Death onth ember	Day 23, 1	Year 999	3. Tim	a of Death
/Medical Examiner	4e Fecility Neme (If not institution,	giva street and number)			4b. City, Town	n, or Location		4c. County			
	Greater Baltim	ore Medical	Center			Towson	1		Balt	imor	e	
uneral			ga (In yrs. last birth	Month	er 1 Year s Days	If Under 24	Hrs. 8. Da	ta of Birth onth, Day, Y	'ear)			te or Foreig
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al Dir	10e. Street and Number 149 Nunnery Lane,	Apt. A-5		10f. 2	Ip Code	212	28	100	. Citizen of V	Whet Cour		
other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	11. Marital Status 1 Nevar Married 2 Marrie 3 Widowed 4 Divorced	12. Wes Decedan Armad Forcas d 1 Yes 25 If Yas, Give Yaar or Datas:	?	13. Was Dec If Yes, sp	ecify Cub	dispante Origin en, Maxicen, I Specify:	n? (Specify Ya Puarto Rican,	as or No- etc.)		e - Americ ck, Whita,		
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er tra	Mr. Jack Christopher	Mabe Gran	dson	147 N	unnery	Lane Apt	t. B-5 Cat	onsville,	Marylan	d 2122	8	
	20a. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donation 5 Other (Spe		20b. Place of Coematary,	crematory o	r othar pla	ca) ervices, In	Dete		Syl	City or To		
any injury or anse.	21. Signature of Funeral Segrice Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 230 Fent. Enter the disease, procomplications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest,											
cian	Pert1. Enter the disease, or shock, or heart fellure. List or limited at Causa (Final disease or condition	nly one ceuse on each	line.		oda of dyi	ng, such as ca	ardiac or raspi	ratory erres	it,	1 1	Approxi Interval Onset a	Batween and Death
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Medical Examiner	Sequentially list conditions, if any, laading to immediate ceuse. Entar Undardying Causa (Disaasa or injury that initiated avants resulting in daeth) Lest	cChron	ic Obstru			onary I	Disease	2			unk	nown
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director, pag	25. Was cesa refarred to madical axaminer?	Hospital:	iant 2 ER/Outp	patient 3	DOA Ot	har:	of Deeth (Che		1000	ar (Sneci	(v)	
funeral di	27. Mennar of Death	28a. Dete of Ini	ury 28b. Ti	me of	28c. Inju Wo						,,	
completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	1 DMaturel 5 Panding 2 Accidant invastige 3 Suicida 6 Could redeferming	ot ba 28a. Place of Ir	niury - At homa, farr	M n, straat, fact	1	Yas 2 No	28f. Lo	28d. Dascribe how injury occurred 28f. Location (Street and Number or Rural Routa Number,				Number,
Cert	4 Homicide	building, a	fc. (Specify)				Ci	ty or Town,	Stata)			
completely filled in by the		Physician: To the best taminar: On the basis and manners	of axamination and/									se(s)
N Com	29b. Signature and title of certifier				9c. Lican	sa numbar		290	d. Date signe	ed (Month,	Day, Yes	ar)
	100 6	2	e		D43	,003			12/29/	1999		
5	30. Nama and addrass of person w Nathan A. Dur				N Cha	rles S	t., To	wson,	MD 2	1204		
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Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month SANDERLIN December 31 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner BALTIMORE Johns Hopkins Bayview Medical Catr 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hrs. Birthplece (Stelle or Foreign Country) 218 86 733. 10M 20F Yrs. 04 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No BALTO Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21206 4000 by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Ricen, etc.) Rece - American Indian, Black, White, etc. 11. Meritet Status 12 Never Married 2 Merried 1 ☐ Yes 275 No If Yes, Give Yeer or Detes: 1 ☐ Yes 2 18€No Specify: BLACK 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) FOOD SERVER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) EMILY SANDERLIN LOBERT JOHNSON 19e. Informent's Neme/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) BALTOMD 21206 MOTHER 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 1 Burial 2 □ Cremation 3 □ Removel from State 4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funerel Service Licensee BALTO MD 21201 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest shock, or heart fellure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediete Ceuse (Finel diseese or condition resulting in deeth) day 5epsi5 Due to (or es e consequence of): Examiner Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert tl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown Syndrome 24b. Were autopsy findings aveilable prior to completion of ceuse of death? Completed 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28c. tnjury et Work? 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred Certification: 1 Netural 2 Accident 5 Pending Investigation 1 ☐ Yes 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

Division of Vital Records,

the buriel-transit ettending physician for use as the burie been signed by the e should be deteched f Director: After this certificate has filled in by the funeral Attending deeth. To the Mospital or Att within 24 hours aftar d To the Funeral Direct completely filled in by

Funeral

Director

7 ie marked other than "natural", or itema 23a or 28a-f ahov traumatic event, the Medical Examiner must be notified at

"natural",

permit. Pages 1 and 2 should be filed within 7. Department of Heelth and Mental Hygiene. important: if fem 27 is marked other than "ne any Injury or other traumatic averages.

Physician

/Medical

Examiner

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filed within 72 hours after deeth with the Meryland

Baltimore, Maryland 21215-0020

Registrar

edicai

29a. Certifier

29b. Signeture end title of certifier

156 Certifying Physictan: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted. 29c. License number 29d. Dete signed (Month, Dey, Year)

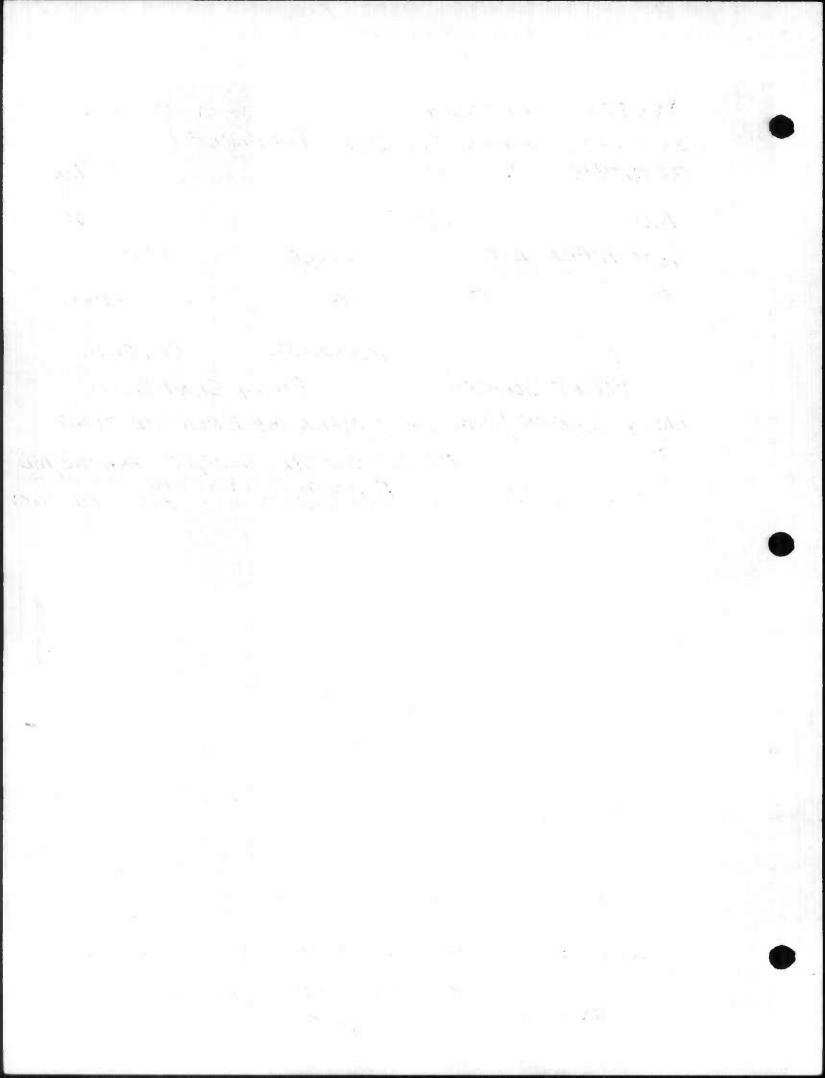
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30. Neme and eddress of person who completed cause of deth (Item 23e) (Type, Print)

Hopkins Bayview Hosp MCKenzic Johns 32. Registrat's Signeture 31. Dete tiled (Month, Day, Year)

MD

JAN 052000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day Year 9 4c. County of Death **Physician** Dec Doris N. Stefkovick /Medical 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie Mariner Health 7. Age (In vrs. 80 5. Social Sacurity Number last birthday) 8. Date of Birth (Month, Day, Year Birthplace (State or Foraign Country) **Funeral** Days Months Hours Director 110-26-4017 20, Ohio Oct Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits or 28a-f show other traumatic event, the Medical Examiner must be nothing at MD Anne Arundel Glen Burnie 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 7355 Furnance Branch Road Funeral 21061 USA_ 14. Raca 12. Was Decadant Evar in U,S. Armed Forces? 1 ☐ Yes ② No If Yes, Give "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) Amarican Indian, 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after to Depenment of Health end Mental Hygiene. Important: If them 27 is marked other than "natural" any injury or other traumatic exercises. Black, White, etc. 1 Nevar Married 2 Married White 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 K Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) 0 floor manager sales 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Earl F. Irey Iona Hay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Bandtholtz/daughter 418 Secluded Post Circle #A Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 Donation 5 ☐ Other (Specify) Ronald S. Wade, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD Intl. Enter tha disease, of complications that caused the daath. Do not anter the moda of dylng, such as cardiac or respiratory arrest, tock, or heart feliure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** End stage Chronic Obstructive Pulmonary distance Coverage acting diseases Due to (or as a consequence of): Immediata Cause (Final disease or condition resulting In deeth) /Medical Examiner Physician/Medical Examiner physician end the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated avents resulting in deeth) Last Sclerotiz Cardiovascular disease Box 68760, SE use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 0 1 Yes 2 No 3 Probably 4 Unknown Records, P. signed t þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☑ No Division of Vital 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28c. Injury at Work? 28d. Describe how Injury occurred al or Attanding P s efter death. I Director: After od in by the funer 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours eft To the Funeral Di completely filled in 1 🗹 Certifying Phyaician: To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(s) and manner es stated. 29e. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

29c. Licansa number

3708 MOUNTAIN Rd. PASAdeNt Md. 21122

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ss of person who completed cause of death (Item 23a) (Type, Print) to then debon 14 M.D. 3708

32. Registar's Signature

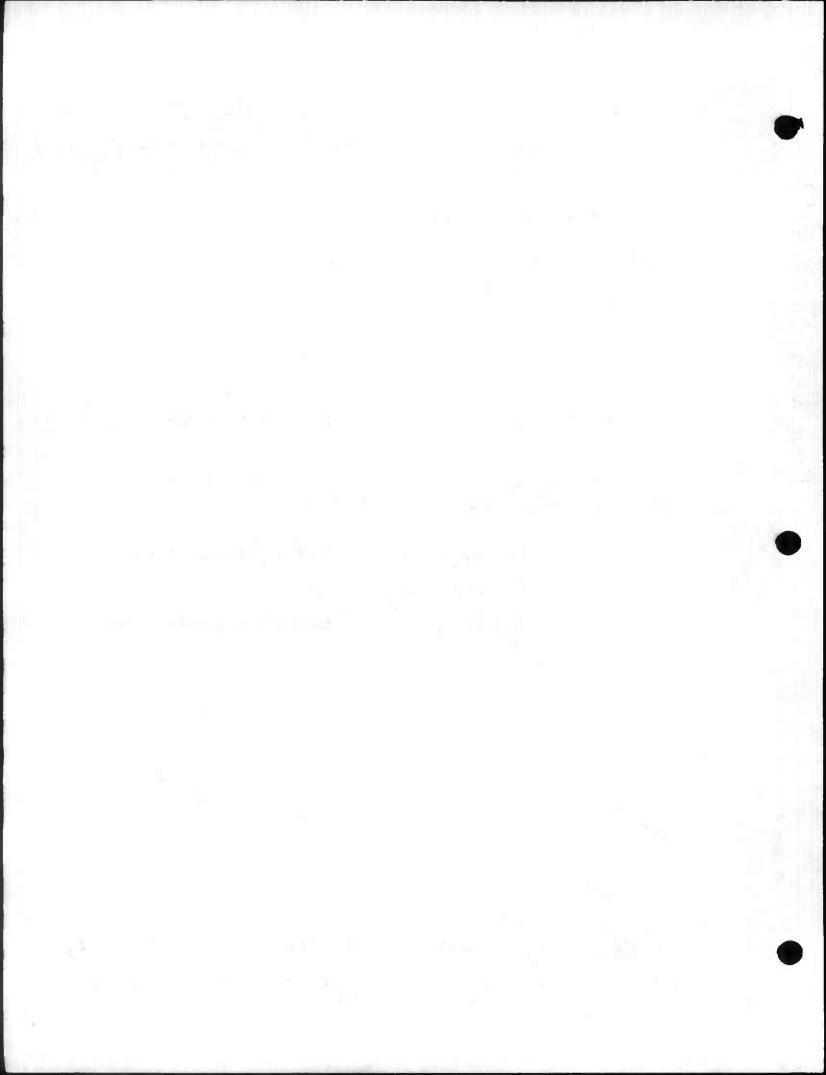
29d. Data signed (Month, Day, Yaar)

State Registrar 29b. Signature and title of certifier

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JAN 05 2000

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Baltimore, Maryland 21215-0020

Funeral

Director

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filed within 72 hours after death wi Hygiens. other than "natural", or flems 23a

death with the Maryland

permit. Peges 1 and 2 should be filed with Department of Heelth and Mentel Hygiene Important: If Item 27 is marked other that any injury or other traumatic event, that place. 19a. Informant's Name/Ralationship (Type, Print) Franklin Square Hospital 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4□Donation 5♥Other (Specify) in state 21. Signatura of Fugaral Service Licensee Wade, /Director 21201 Baltimore, MD **Physician** · SEPSIS /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Examine PNEUNOVIA physician and the burial-transit thet the deeth certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760, Physician/Medical Dua to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. DEMENTIA, PERIPHERAL LASCULAR DISRASE λq Records.

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signetura

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JAN 05 2000

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31. Data lilad (Month, Day, Year)

41638 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** 3.50 P.M. DECEMBER 26, 1999 Alma Stockman /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City. Town. or Location of Death 4c. County of Death Examiner ROSED If Under 24 Hrs. FRAKKLIN SOWARR HOSPITAL CENTRR ALTIMORE 8. Data of Birth (Month, Day, Year) Apr 23, 1910 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Year 9. Birthplaca (Stata or Foreign Days Hours 1□M 2XF unknown 186-10-4969 Usual Rasidanca of Dacadant 10a. Slata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√2 Yas 2 No Director Baltimore MD N/A 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21221 Eastern Blvd Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Was Decedent Evar in U,S. Armed Forces? 14. Race - Amarican Indian, 11 Marital Status Bleck, White, etc. 1 ☐ Yas 2 ☐ No If Yas, Giva 1 Nevar Married 2 Married Specify: white 1 Yas 2 No Specify: à 3 ☑ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant'a Education (Specify only highast grada completed) 16b. Kind of Businass/Industry College (1-4or 5+) unknown Elementery/Secondary (0-12) unknown unknown unknown 17. Fathar's Nama (Firs), Middla, Last) 18. Mother's Nema (First, Middle, Meiden Sumema) Be unknown unknown 19b. Meiling Addrass (Street and Number of Aural Route Number, City of Jown, State, Zip Gode) 7 20c. Location - City or Town, Stata 23 Name and Address of Feeling oard 655 W. Baltimore Street Part 1. Entar tha disaasa, or complications that caused tha death. Do not enlar tha mode of dying, such as cardiac or respiratory arrast, shock, or heer leiture. List only one cause on each line. Approximate Intervel Between Onset and Death WEEK WEEL 23b. Did tobacco use contribute to the cause of death? 1 Yes 2U No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to 24a. Was an autopsy Completed BILATERAL ABOUR THE KNEE AM. completion of cause of death? 2HTNO PUTATIONS 1 □ Yas 2 □ No 25. Was case rafarred to medical axaminar? Be 26. Place of Deeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 Inpalient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Netural 5 Panding invastigation 1 Yes 2 No 2 Accidant 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datarmined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicida 29a. Cartifian 12 Certifying Physician: To tha best of my knowledga, death occurred at the tima, data and place, end due to the cause(s) and menner as stated. edical (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and placa, and dua to the cause(s) end menner stated. 29b. Signatura and title of certiful 29c. License number 29d. Data signed (Month, Day, Year)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Registrar

Division of Vital

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he Hospital or Attending Pin 24 hours after death.

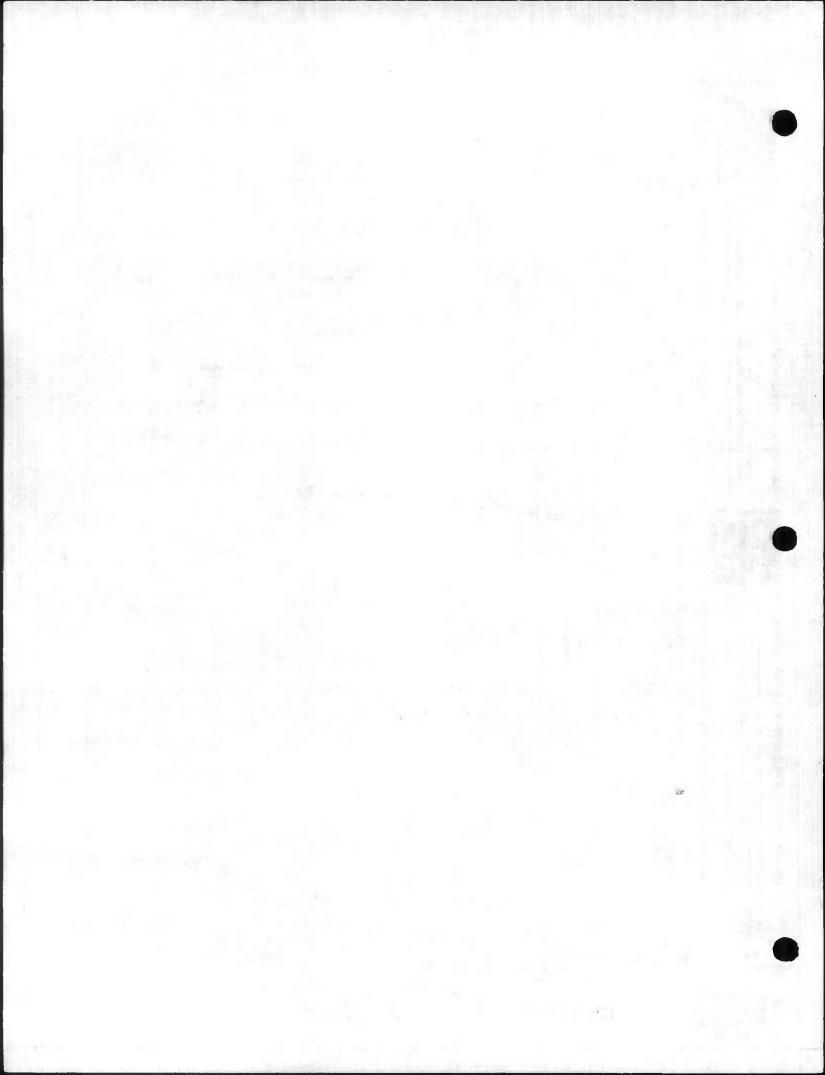
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) CARHS Day 08 Month L1BB4 Damen 30 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BACTIMONE HOSPITAL PANDAIIS TONA NORTHWEST If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours 1□M 2X0F 78 214-14-9077 **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD RALTIMORE OWINGS MILLS 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5313 WAGON SLED CIRCLE U.S.A. 21117 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Merried WHITE 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tite. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY BALTIMORE COUNTY SCHOOLS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) HARRY WEISS PEARL DIAMOND 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELVIN H. SACHS / HUSBAND 5313 WAGON SLED CIRCLE - OWINGS MILLS, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removel from Stete MARYLAND VETERANS CEMETERY 1/3/2000 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signeture of Funeral Service Licensee SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Tole 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 43 Henrs Immediate Cause (Finel SEPSIS disease or condition resulting in death) Due to (or es a consequence of) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? PHOUMONIA CIN'NAW THACT WIFECTO 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy performed? QUADREPARISCS antli Tree SIABETIS 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical axaminer?
1 Yes 2 No 26. Place of Deeth (Check only one) Hospitel: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stefe) 6 Could not be determined

Box 68760, P.0. Records, of Vital Attending Physician: Division

Examiner The law requires that the death certificate be executed 945 To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A filled in by Medical

Physician

/Medical

Examiner

Funeral

Director

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Pages 1 and 2 should be 1 nent of Health and Mental I int: If Item 27 is marked of

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Department of Important: If eny Injury or

Physician

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Examiner

filed within 72 hours after

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Maryland

Baltimore,

Director

Funeral

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Completed

Completed by Physician/Medical å

Certification: To

3 ☐ Suicide

4 Homicide

(Check only one)

Registrar

29b. Signeture and title of continue

and

28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

19502 PANDAUSTON, MI 2/133

29d. Date signed (Month, Dey, Year) Decompora 30, 1999

30. Name and eddress of person who codeause of death (Item 23a) (Type, Print) ORIANDO B. CONTRAD 40

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner steled.

31. Date filed (Month, Day, Year) JAN 05 2000

32. Registrar's Signeture

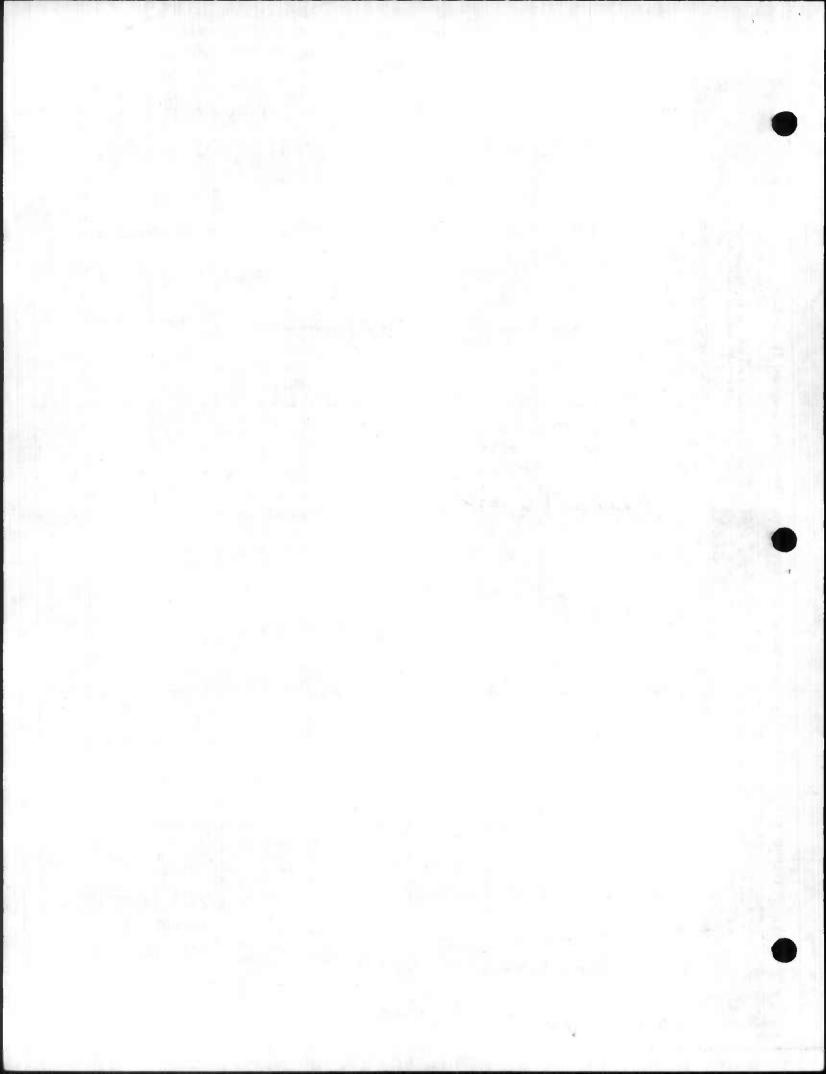
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State of Maryland / Department of Health and Mental Hygiene 99 41640

				Cert	ificate o	f Death		R	eg. No.	7 4	1046
1. Decedent's Nama (First, N	fiddle, Last)						2.	Date of Dea Month		Year	3. Tima of De
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Usual Residence of Deceden	717										
MD N. State 10b. Co. MD N. 10e. Street and Number	unty		10c. City, To				1			10	d. Inside City I
MD N	A		Bal	timo							1 Yes 2
10e. Street and Number 3478 Spel	lman	Road			10f. Zip Code 21:	225		10g. Citizen of Whet			y?
11. Merital Status 1 Never Merried 2 3 Widowed 4 Divo	Married	2. Wes Decedent Armed Forces? 1 Yes 27 If Yes, Give Year or Dates:		.S. 13. Wes Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl		gin? (Specif , Puerto Ric	y Yes or No- an, etc.)	Bled	ce - American Indien, eck, Whita, atc. ify: Black		
15. Dece (Specify only hi	dent's Educ	cation completed)	16	(Give ki	nt's Usuet Occ nd of work do	ne durina most	of working		16b. Kind of B	usinass/Indu	stry
Elementery/Secondary (0- 6th Grade	12)	College (1-4or 5 NA	i+)	Labo	NOT use ret	ired)			Brick	Comp	any
17. Father's Neme (First, Mid	idle, Last)					18. Mother	r's Neme (F	irst, Middle,	Maiden Sumen	ne)	
Claude P.	Tho	mas				Mab			cKeith		0.7
19a. Informant's Neme/Relet		oe, Print)				eet end Number					
Brenda Br: 20a. Mathod of Disposition	ice		- to		Spell.	lman R			more,		
tmmediete Cause (Finel disease or condition resulting in death) Sequentialty list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{ b. c. d.	Diabete Obesi	Due to (or es of Due to	e // f	ence of):					1	ntervel Between Conset and Des In Know. In Know. In Know. In Know.
Part II. Other significant con-	ditions cont	ributing to death b	ut not resulting	in the und	ertving causa	given in Part I		23b. Dld to	obacco use co	ntribute to	the cause of (
					, ,				'es 2□ No		/
					4			24a. Was e perfor	med?	com	e eutopsy find lable prior to pletion of cause eeth?
25. Wes case referred to mee	dia							1 🗆 Y		10	Yes 2□ No
examiner?	_	ospitat:	or appear	Outpatient	3□ DOA	Other		Check only or	ne) ence 6 □Oth	or (Consibil	
27. Manger of Death 1 ☑Netural 5 ☐ Pe	nding estigation	28a. Dete of Injui (Month, Day		. Time of Injury	28c. Ir		280		ow injury occur		
	uld not be termined	28a. Plece of Injubuilding, etc.	ury - At home, c. (Specify)	farm, stree	t, factory, offic	be .	281	Location (S City or Tow	treet end Numb n, Stete)	ber or Rural	Routa Numbe
29a. Cartifier 1 Certifier (Check only 2 Medi	ifying Physi cal Examin	ician: To the best of er: On the basis of and menner sta	examination e	ge, death o and/or inve	ccurred at the stigation, in m	time, date end y opinion, deet	d place, end h occurred	due to the c et the time, d	ause(s) and me late end piace,	enner as sta end due to	ted. he cause(s)
29b. Signature and fitte of ber	tifier _ }	//	/		29c, Lice	ense number		2	9d. Date signe	d (Month, D	ay, Year)
► 1000	4 11	guyn	ypl			2025	2	D	ECEMBO	R 3	1 199
30 Name and address of pen	NYCH	+ MD	eath (Item 23a	(Type, Pr	3001	S. HAN	JOVER	. St.	BALTIN	norE,	MD.21

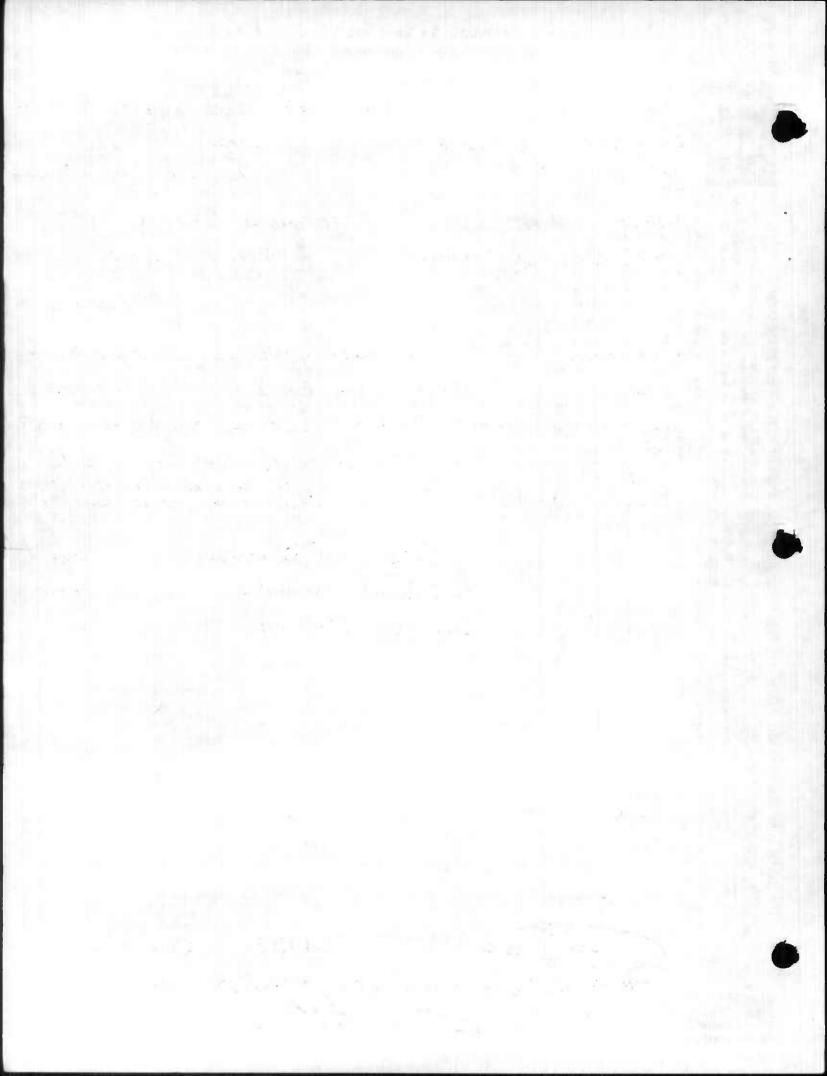
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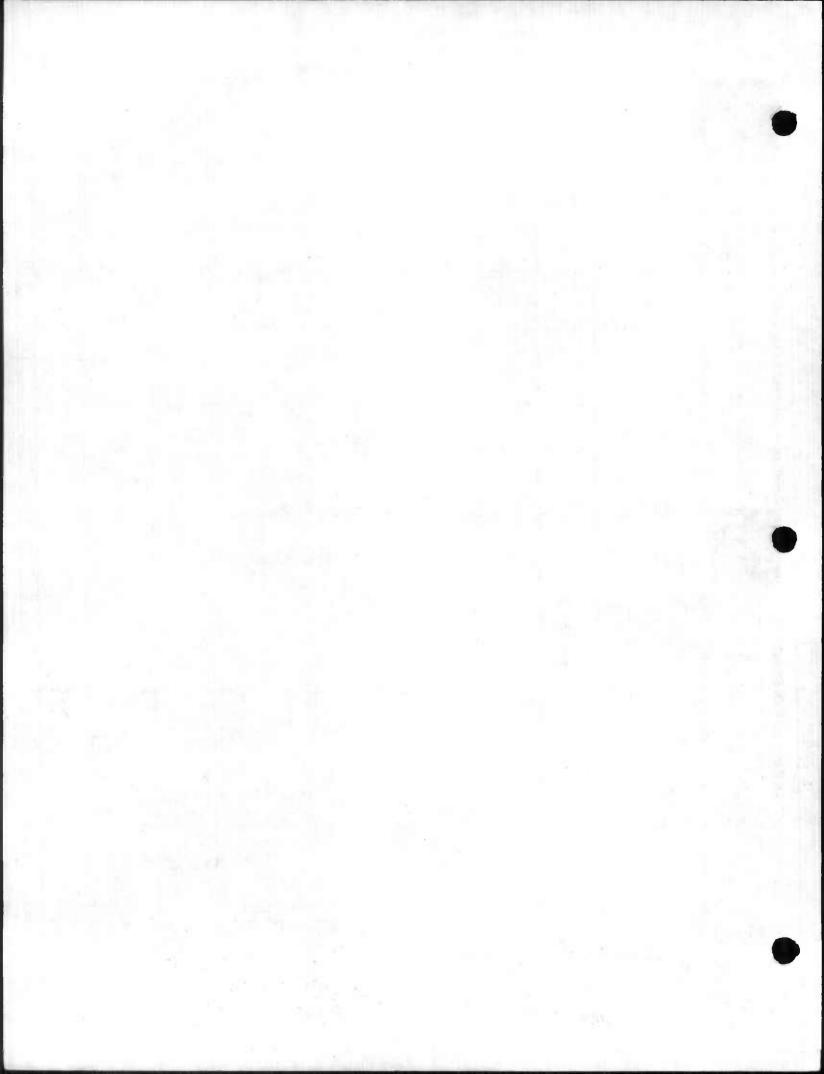
	Certificate of Death	Reg. No.	
Physician /Medical	WHEELER THOMPSON	2. Date of Deeth Month Day	1999 4:05 P.M.
Examiner uneral rector	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Deys Hours Min.	ation of Daath 4c. Co 7 MORE 8. Dete of Birth (Month, Day, Year) NOV 20, 192	Ounty of Deeth W A 9. Birthplece (State or Foreign Country)
show ad at	Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location	1	10d. Insida City Limits
28a-f al notified rector	MARYLAND N/A Street and Number 101. Zip Code	E CITY	1. Yes 2□ No en of Whet Country?
al Die	2925 BELMONT AVENUE 21218	,	USA
by Funeral Director	11. Maritel Status 12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☐ Never Married 2 ☐ Merried 3 ☐ Widowed 4 ☐ Divorced 12. Wes Decedent Evar in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Yaer or Detes: 13. Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 ☐ No Specify:	cify Yes or No- lican, etc.)	8. Rece - American Indian, Black, Whita, atc.
	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of workin, life. DO NOT use retired)	16b. Kind	d of Business/Industry
e Completed	10 TH GRADE CONSTRUCTION WOR		STRUCTION Company
To Be	JOE THOMPSON ELIZA	7	STUKES
	19a. Informent's Neme/Relationship (Type, Print) MARY MCDONALD (NIECE) 19b. Melling Addrass (Street end Number or Rural 7007 BEX HILL ROA 20e. Method of Disposition 12b. Place of Disposition (Name of cemetery, cremetory or other place) 4 □ Donetion S□Other (Specify)	Dete 20c. Loca	ORE, MD. 2/207 ation - City or Town, Stete
BOCK	21. Signature of Funeral Service Upgaee 22. Nama end Addrass of Fecility 22. Nama end Addrass of Fecility 23. SEPH H. BA	POWN JR.	FUNERAL HOME LTO, MD. 21217
in	23e. Pert1. Enter the diseesa, or complications thet caused the daeth. Do not enter the mode of dying, such es cardiac or shock, or haart failure. List only one cause on each lina.	raspiratory arrest,	Approximete Intervel Between Onset end Deeth
al er	Immediate Couse (Finel disease or condition resulting in deeth) a. Sepsis and Dehy Bo	ration	DAYS
liner	Due to (or as a consequence of): Multinfart Dementia		years
n/Medical Examine	Sequantially list conditions, if any, leeding to immediate causes. Entar Underlying Ceuse (Diseese or Injury that initiated evants resulting in death) Lest Due to (or as a consequence of): Due to (or es e consequence of): d.		years
Physician/M	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacco u	ee contribute to the cause of death?
by Phy		1 ☐ Yes 2	No 3 Probably 4 Unknown
Completed b		24a. Wes en eutops performed?	24b. Were eutopsy findings available prior to completion of cause of death?
		1□ Yes 24	No 1 □ Yas 2 □ No
To Be	25. Was casa referred to medicel axaminer? 1 Yes 2 No	(Check only one) ne 5 Rasidance 6	Other (Specify)
Certification: T	27. Mannar of Death 1 Papartural 5 Pending (Month, Dey Year) 28a. Data of Injury (Month, Dey Year) 28b. Tima of Unjury Work? 1 Yes 2 No	8d. Dascribe how injury	occurred Number or Rural Routa Number,
Certif	3 ☐ Suicide 4 ☐ Homicida 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)	City or Town, Stata)	ramber of ridial roots rambor,
Medical Ceri	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and mannar stated. Check only one)	nd dua to the cause(s) e d et tha tima, data end p	end menner as stated. Dlace, and dua to tha cause(s)
Σe	29b. Signature and time of contilior Attendities 29c. License number	29d. Date	signed (Month, Day, Year)
	D17118	Jan	03,2000
6			
5	29c. License number D 17 18 30. Halfred M.D. 115 E. Mclace 31. Dete filed (Month, Dey, Year) JAN 05 2000 29c. License number D 17 18 Apartha Apartha	Ave 212	12

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Alvin Lerov Thomas 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Alvin Leroy Thomas 7, 1999 DECEMBER 1605 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY BON SECOURS HOSPITAL N/A 7. Age (In yrs. last birthday) 50 yrs. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2 □ F Yrs. Director unknown unknown Usual Residence of Decedent with the Maryland 10a. Stete 10c. City, Town or Location 10b. County show 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Baltimore Directo Baltimore 288-4 MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Name 23a or 21122 USA 366 Rambling Ridge Ct Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Meritel Stetus unknown Black, White, etc. Illed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Merried 8 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Detes: unknown black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. other than Elementary/Secondery (0-12) College (1-4or 5+) unknown unknown unknown unknown Maryland 17. Father's Neme (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental I 8 2 unknown Pages 1 and 2 should nent of Health and Men unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Intormant's Name/Reletionship (Type, Print) nt of Health a If Item 27 is or other tra 111 Penn Street Baltimore, MD O.C.M.E. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete Department important: If 4 □ Donetion 5 Other (Specify) in State 21. Signature of Euperal Service Licensea de Director 3 Narce and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Pent. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Finel disease or condition resulting in deeth) Cocaine and Narcotic Intoxication **Examiner** Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as e consequence of): signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to Completed 24a. Was an autopsy performed? Deen completion of cause of death? 1 Yes 2 □ No 1 XYes 2 □ No this certificate Attending Physician: funeral director. Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient XXXER/Outpatient 3☐ DOA XX Yes 2□ No Certification: To 28a. Date of Injury (Month, Day Year) Found: 12-07-1999 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Menner of Deeth After Found: 1:05 P 1 Neturel 5 Pending 1 Yes 2 No Unknown death. investigation I or Attendi after death Director: A 2 Accident Could not be 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Myrtle_Avenue, filled in Alley To the Hospital within 24 hours a To the Funeral Completely filled Baltimore, Maryland 29e. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated edical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OCME DECEMBER 8, 1999 prodon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Theodore King M.D. 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State heren JAN UZ SUUD Registrar



99-7806-510 B.K.S		Type or Print in E	Black Indelible Ink	c. Assure Al	l Coples A	re Legit	ole.			
ROBERT TISI	DALE 'EMS: #23 PART	State of Marylan	nd / Department of p	Health and M		ene 9	9 4	1643		
Physician	1. Decedent'e Name (First, Middle, L	ast)	LERTH		2. Date of Death Month	Day 7, 199	Year	3. Time of Death		
/Medical Examiner	ROBERT T. TISDA 4a Facility Name (If not institution, g BON SECOUR HOSE	ive street and number)	4b. City, Town, or Lo	ocation of Death	UIDD AM					
*Funeral Director	215-58-1368	Sex 7. Age (In yrs. 47	last birthday) Yrs. If Under 1 Yee Months Days		8. Date of Birth (Month, Dey, Y 9-28-52			e (State or Foreign) MD •		
Maryland H show Fed at	Usual Residence of Decedent 10a. Stete 10b. County MD . N/A		y, Town or Location ALTIMORE				10d.	Inside City Limits Yes 2 No		
ter death with the Manylan Herra 23a or 28a-f ahow Iner must be notified at Tuneral Director	10e. Street end Number 1323 N. FULTON	10e. Street end Number 1323 N. FULTON AVE. 21217						7		
020 urs at at', or by F	3 ☐ Widowed 4 ☐ Divorced Year or Detes:							fndian,		
within then.	15. Decedent'e (Specify only highest g Elementery/Secondary (0-12) -12-	Education rede completed) College (1-4or 5+) -4-	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	upation e during most of work ed)	ing 16	b. Kind of Bu	siness/Indus	ilry		
Maryland 2 d 2 should be filed d 2 should be filed f 1s marked other fraumetic event, to	17. Father's Name (First, Middle, Last) RICHARD M. TISDALE 18. Mother's Name (First, Middle, Maid VASHTI A. ALSTON									
2 2 2 2	19e. Informant's Neme/Reletionship BEVERLEY ALSTON	N(SISTER)	19b. Meiling Address (Street 2315 CALVERT		AVE. BALT	IMORE,	MARYI	LAND 2121		
Se	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	□Removal from State ify) MT.	Place of Disposition (Name of cemetery, cremetory or other placements)	1-	-3-2000 в		RE, M	ARYLAND		
Baitin permit. Pe Departmen important any Injury pnce.	21. Signature of Funeral Service Lice	D. Hisner	ILLIPS FU I. BALTIM							
Physician /Medical	23a. Per/1. Enter the disease, or continued, or heart feiture. List onli	y one cause on each line.			or respiratory arres	t,	fn	pproximete terval Between nset and Death		
Examiner ਹ	disease or condition resulting in death)	e								
60, the executed sician and buriel-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	bDue to (c	or as a consequence of):							
ficete sphy se the	Cause (Disease or Injury that initiated events resulting in death) Last	Due to (o	or as e consequence of):							
P.O. B that the death of the atterded for Physicial	Part II. Other eignificant conditione	given in Part I.				ne cause of death? bly 4 5 Unknown				
ecords aw requires ss been sign 2 should be		P			24a. Was en performe		eveila	autopsy findings able prior to eletion of cause ath?		
= F # E 0	25. Was case referred to medical			26. Place of Deet	h (Check only one)	2 No	101	/es 2□ No		
of Vita hysicien: this certific al director,	examiner?	Hospitel: 1 Inpatient 2X	FR/Outpatient 3□ DOA O	ther: 4 Nursing Ho	me 5 Residen	ce 8 Othe	or (Specify)			

Division of Vital Records, P.O. Box 68760.

To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral

Medical Certification

29e. Certifier (Check only one)

1 Netural

2 Accident

3 SuicIde 4 - Homicide

5 Pending investigation 6 X Could not be determined

28b. Date of Injury
Found:
12-27-99
28b. Flece of Injury At home, farm, street, factory, office building, etc. (Specify)
FOUND: RESIDENCE

UNKNOWN

281. Location (Street end Number or Rural Route Number, City or Town, State) 1327 N. FULTON AVE. BALTIMORE, MD AVE. 1 Certifying Phyelclan: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier um

29c. License number O.C.M.E

29d. Date signed (Month, Day, Year) DEC. 27, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H 1 4 Penn

31. Dete filed (Month, Dey, Year)

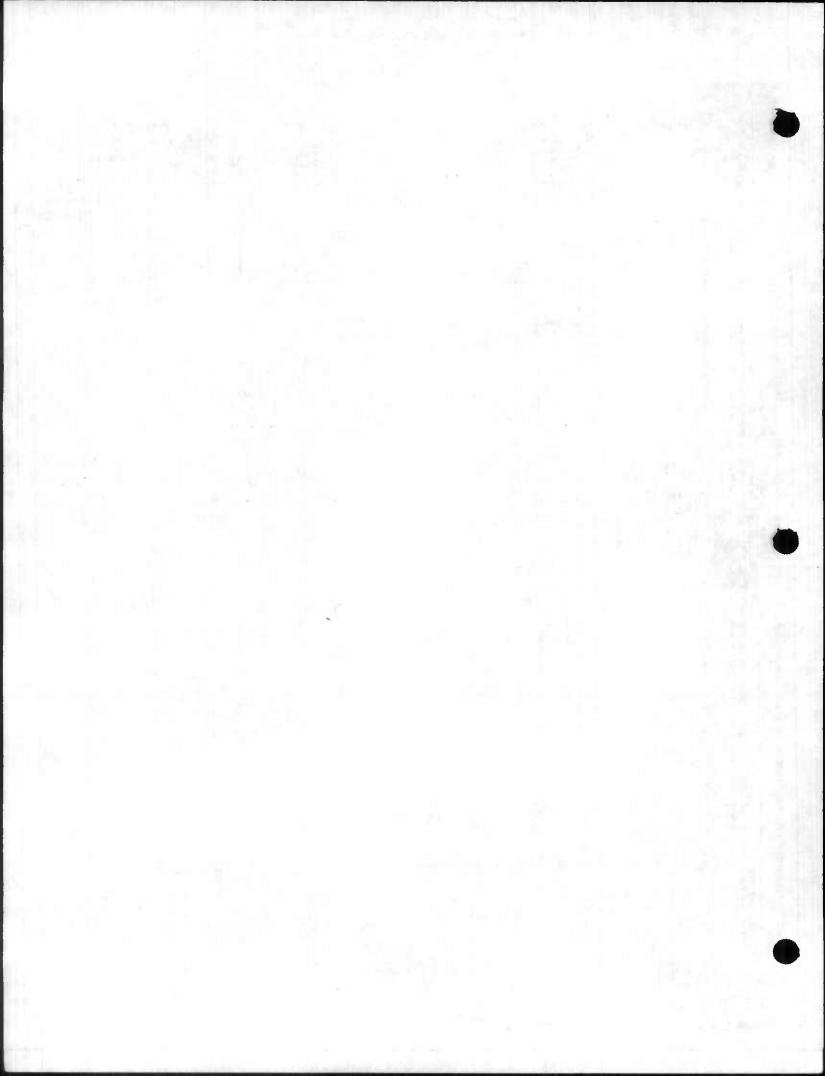
JAN 0 5 2000

32. Registrer's Signeture

Penn Street, Baltimore, Maryland 21201

State

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month Edith 5. Wilson 17:00 Am December 24, 1999 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Deeth ParKville Oakcrest Baltimore Care Center 5. Sociel Security Number 6. Sex If Under 1 Year if Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplece (State or Foreign Country) Deys 1 M 25 F 90 217-58-8556 Yrs. April 28,1909 Maryland Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits Baltimore 1 ☐ Yes 2 No arKuile 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8300 walther 2 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) Rece - American Indian, Black, White, etc. 11. Maritel Stetus 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify. Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 10 Homemaker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) John Margaret Morrow 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) arol Birkhead - daug 2620 Drive Claret Fallston, mD2104 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) Dete 20c. Location - City or Town, Stete Dec. 29. Buriel 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 1999 Baltimore, MD Cernetery Daklawn 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility Evans Maper of memories 23a. Per1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. 1234 Approximete Intervel Between Onset end Death Artemoscherolic cardiovascular disease Immediate Cause (Final disease or condition resulting in deeth) Due to (or es e consequence of): pertension Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initialed events resulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evelleble prior to completion of ceuse of desth? 24a. Wes en eutopsy performed? 1 Yes 2 1No 1 ☐ Yes 2 No 25. Wes cese referred to medical 28. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes SKINO 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

10e. Stete

Funeral

Director

28a-f show

6 death with

items 23a

permit. Peges 1 end 2 should be filled within 72 hours effer (Department of Health end Mental Hygiene. Important: if Item 27 Is marked other than "natural", or Iten any follury or other traumatic event, it a Medical Examinat Boos.

Baltimore, Maryland 21215-0020

Director

þ

Completed

Be

traumatic event, the Medical Examiner must be notified at

Examiner Physician/Medical ģ Completed Be Certification: To

The law requires that the death cartificate be executed the buriel-transit P.O. Box 68760, for use as ate has been signed by page 2 should be detected Records, After this certificate Division of Vital or Attending Physician: funeral director, To the Hospital or Attending within 24 hours efter death.
To the Funeral Director: Afte completely filled in by the fun

0

Medical

31. Dete filed (Month, Dey, Year) State Registrar

27. Menner of Deeth

1 Neturel

2 Accident

4 - Homicide

3 ☐ Suicide

29e, Certifier

28e. Dete of Injury (Month, Day Year)

29c. License number 3018

1 Certifying Physicisn: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as ststed.

2 Medical Examiner: On the bests of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete end plece, and due to the ceuse(s) and menner steted.

28c. Injury at Work?

1 Tyes 2 No

29d. Dete signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print) William Russell

5 Pending Investigetion

6 Could not be determined

8800 Walther Blud

28d. Describe how Injury occurred

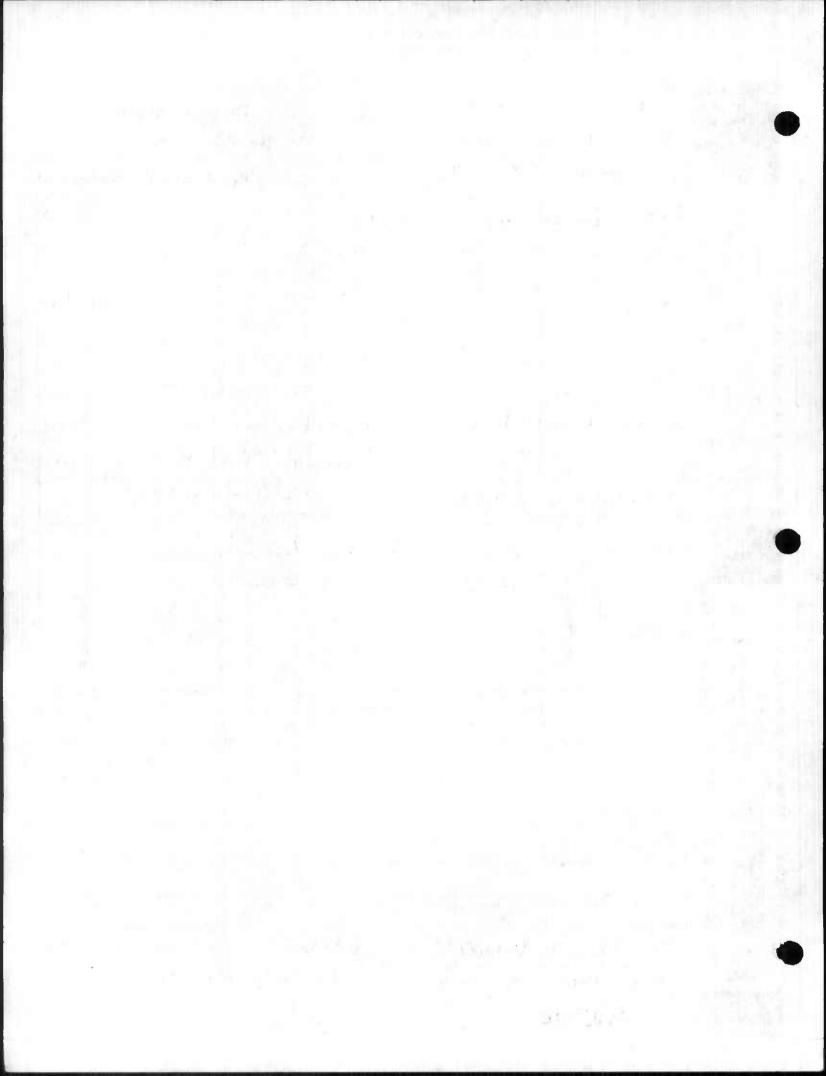
JAN 0.5 2000

29b. Signeture end title of certifier

32. Registrer's Signature

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** 3 IAMS DEC 7:55PM MON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (I not institution, give street and number) Examiner RAMBLEWOOD BALTIMORE KOAD If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months Days 842 23 Hours -30-1 M 2□ F Director NORTHO Usual Residence of Deceder the Maniend 10a State 10b. County 10c. City, Town or Location ahow 10d. Insida City Limits the Medical Examiner must be nothing at 12 Yes 2 No Director MARULAND 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 AMBLEWOOD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA 14. Race - Amarican Indian, "natural", or Items 23s KOAD 160 Funeral death 12. Was Decedent Ever in U,S. Armed Forces?, 1 Yes 2 Z No If Yes, Giva Year or Dates: 11 Marital Status Black, White, etc. filed within 72 hours efter 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. mentary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Heelth and Mental Hyglers important: If them 27 is marked other than eny injury or other traumatic event, the DRGB. 4 HAGRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 NEAL MILLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 RAMBLEWOOD ROAD WILLIAMS NNIE WIFE 164 BALTIHORE, MD-21239

20c. Location - City or Town, Stata Method of Disposition

1D Burial 2 Cremation 3 Removat from State 20b. Place of Disposition (Name of cametery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) ULANEY VALLEY CEMETERY 01-05-00 COCKEYS VILLE, MO 21. Signature of Furieral Service Liv 22/Name and Address of Facility H. BROWN JR. FUNERAL HOME JOSEPH JOSEPH EPH 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailura. List only one ceuse on each line. 140.2121 Approximate Interval Batween Onsat and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Dua to (or as a consequence of) Examiner ician end buriel-transit or Attending Physician: The law requires that the death certificate be assected Sequentially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Box 68760 Physician/Medical the the Dua to (or as a consequence of): 080 signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes No 3 Probably 4 Unknown þ 24b. Wara autopsy tindings available prior to completion of ceuse of daath? 24a. Was an autopsy parformed? Completed (DNO 1 ☐ Yes 2□ No 25. Was case referred to medicel examiner? Be 26. Place of Death (Check only ona) Hospital: 1 Yes DX No Other: 4 Nursing Home Rasidence 6 Othar (Specify) edical Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Data of Injury (Month, Day Year) Mariner of Death
1-2 Natural
2 Accident 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending 1 Yes 2 No 24 hours after death. investigation 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) 6 4 Homicide filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the ceuse(s) 29a. Certifier completely er: On the basis of exame and mannar stated. (Check only one) within 2 To the 29c. License number 29b. Signature and title at bental 29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar

STANLE 31. Date filed (Month, Day, Year) JAN O

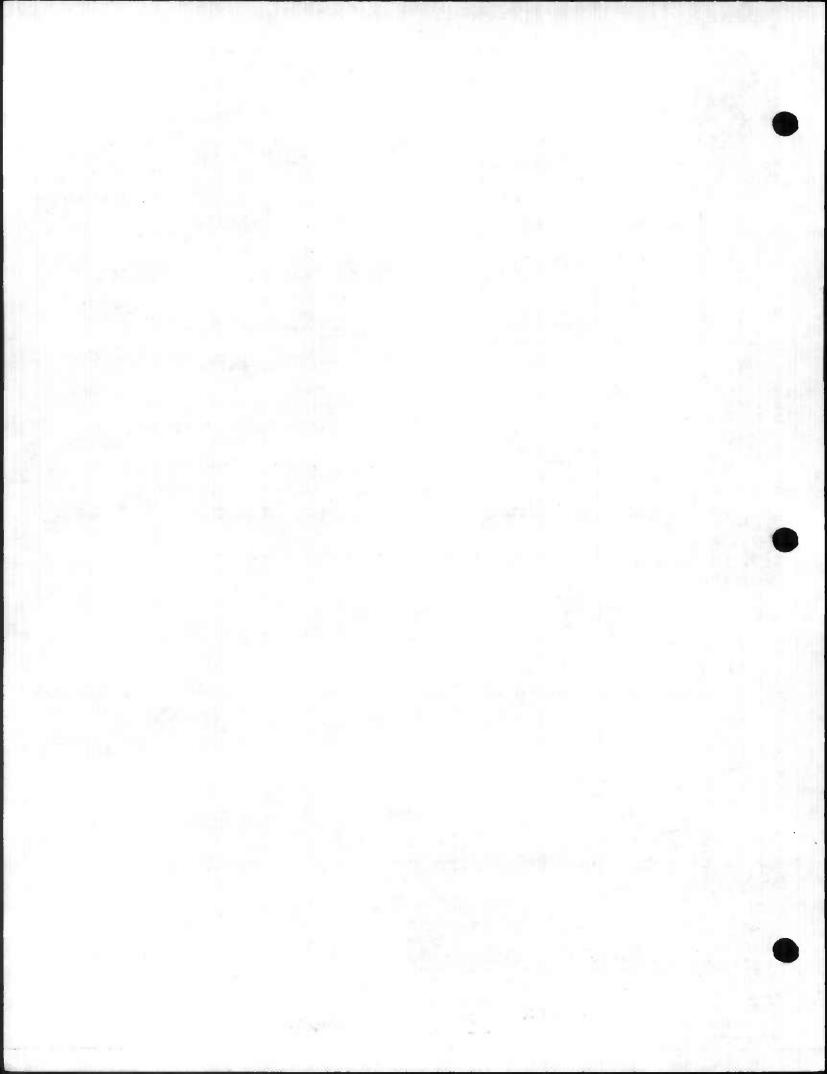
3333 MO. 32. Registrar'a Signature 5 2000

11/10

30. Name and addrass of person who completed cause of death (item 23a) (Type, Print)

WAI

2000



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Bernard Bing Ming Wong December 23, 1999 9:15 am. 4a Facility Name (If not institution, give street and number) -4b. City, Town, or Location of Death 4c. County of Death Baltimore 5

If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 513 North Point Road Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country)
 MD Days 10 M 2□ F Months 218-14-9059 75 September 26, 1924 B Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Baltimore Baltimore 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? USA North Hoint Road 21224 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 D No If Yes, Give / Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritat Stetus Bleck, White, etc. 1 Never Married 2 Married 1□ Yes 2D No Specify: Specify: Asian 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Building Construction 3 Carpenter 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Marie unknown Unknown 19a. Intormant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Mary Wong / 2 20a. Method of Disposition 513 North Point Rd. Baltimore 5 pouse MD 21224 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 12/23/99 Laurel, MD 4 Donation 5 ☐ Other (Specify) Anadomic Gift Foundation 21. Signatura of uneral Service Uctins 22. Name and Address of Facility
Anatomic Gift Foundation 3948 Baltimore Avenue Laurel MD plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, one cause on each line. Approximate Intervel Batween Onset and Death mmediete Cause (Final disease or condition resulting in death) Wisease Sequentially tist conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) Hospitel: Other: 4☐ Nursing Homa 5☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yas 2 ☐ No 3 Suicide

Examiner the burial-transit P.O. Box 68760, 4 signed by t Division of Vitai Records, certificate To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

Physician/Medical

P

Completed

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adical Certification: To

Physician

/Medical

Examiner

Director

Funeral

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r than "natural", or items 23s or 26s-f sho the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiens. Important: If hem 27 is married other than "natural", or leasn't fillury or other trauments.

Physician /Medical

Baltimore, Maryland 21215-0020

25. Was case referred to medical 1 Yes 2 No 27. Manner of Death 1 Naturat 2 Accident

6 Could not be detarmined

28e. Place of tnjury - At home, tarm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, Stete)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to tha cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and menner steted. 29b. Signature and title of certifie

4 I Homicide

29a. Certifier

29c. License number

29d. Dete signed (Month, Day, Year)

molimo 30. Name and address of person who completed causa of death (ttem 23a) (Type, Print)

D50835

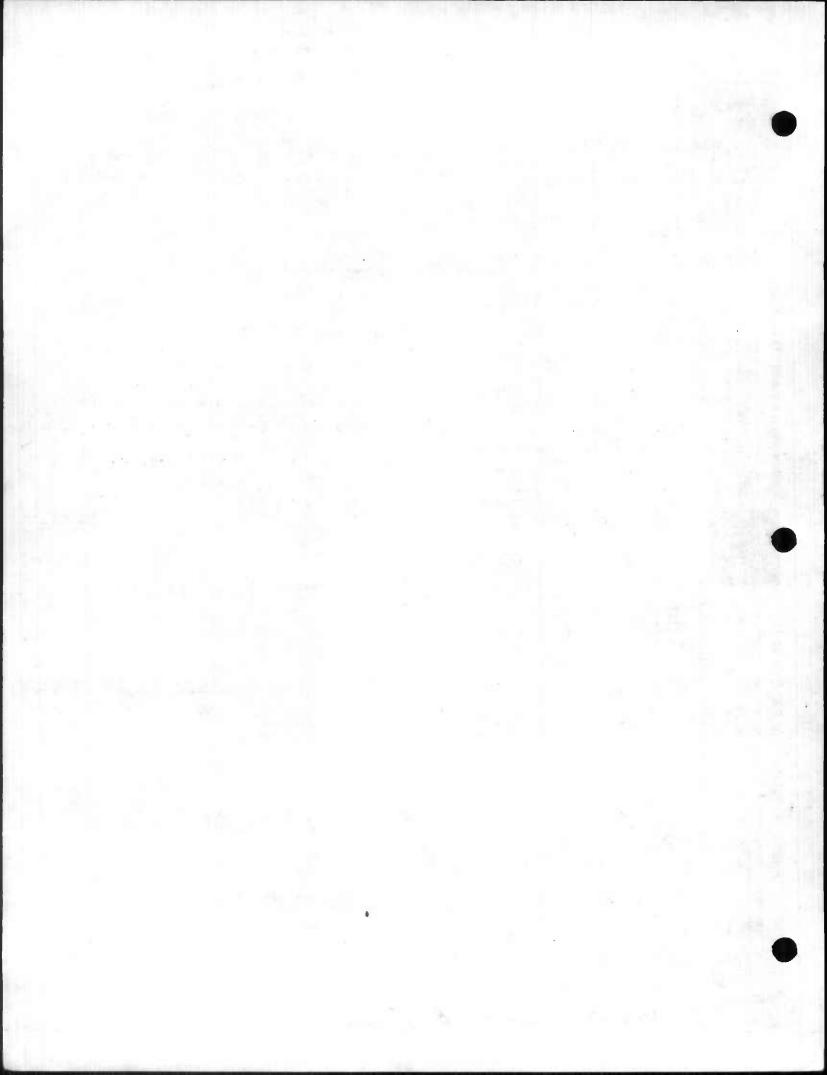
mernt Blvd. Baltimore

Q Registrar

31. Date tiled (Month, Day, Year) JAN 052000

WILLIAM Dando mo 1576 32. Registrar's Signature

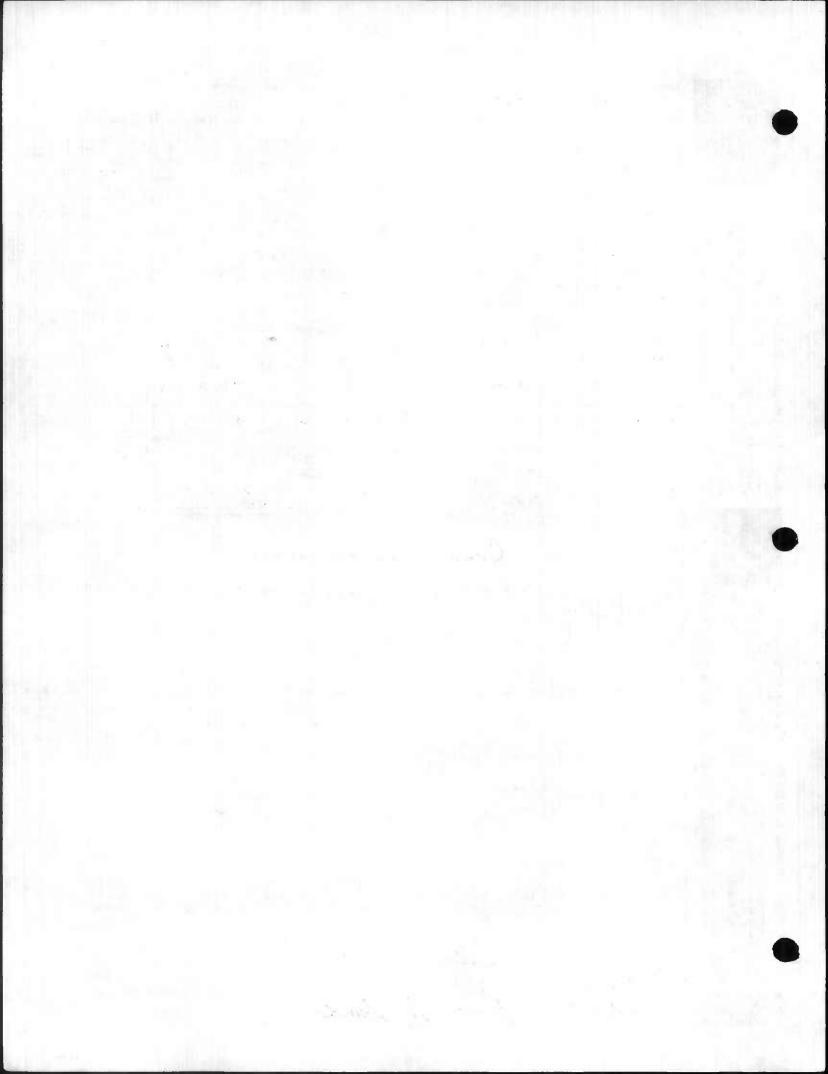
-DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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	V	VILLIAM	H WHIT	E				DEC	31 19	99	9:45 am		
miner	4a Facility Nam	a (If not institution	n, giva street and numb	er)			4b. City, Town, or	Location of Death	4c. County	of Deeth			
Щ		7 Clip					Essex			altin			
al or	5. Social Securi 212–20– Usuel Residence	0190	6. Sex 12⊠ M 2□ F	Age (In yrs. 74	last birthday) Yrs.	Months Days		8. Dete of Birth (Month, Day Jan 1.	3 1925		ce (Stete or Foreign 1) "land		
tor	10a. State MD	10b. County	altimore	10c. Cit	y, Town or Lo	eation Ess	ex		-	10d	I. Inside City Limits 1 ☐ Yes 2€XNo		
Funeral Director	10e. Street and	Number .ipper Ro	pad			10f. Zip Code	21221	1	10g. Citizen of V USA	Vhat Country	n		
þ	11. Meritel Stetu		12. Wes Decede Armed Force 1)X Yes 2 If Yes Give	s? □ No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes 2☑ No Specify: Specify:					k, White, etc	c.		
pa combiered	Elementery/S	Specify only higher secondery (0-12)	t's Education st grade completed) College (1-4	or 5+)	(Give I	OO NOT use retire	during most of wor	king	16b. Kind of Bu	siness/indu			
	12th	<u>)</u> me <i>(First, Middl</i> e,	Last)]		18. Mother's Ner	ne (First, Middle,			.5027		
0		Clar	ence White				1	Ella Wa	alters				
		s Neme/Reletions ny M. Whi	hip <i>(Type, Print)</i> .te / wife				Road Balt				ode)		
		2 Cremation	3 □Removel from Sta	20b. F	Place of Dispos cometery, creme adowri	sition (Name of natory or other pla dge Ceme	tery 1/	Dete 1/2000	20c. Location - Baltir	•			
	21. Signature o	21. Signature of Funeral Service Ucenses 22. Name and Address of Facility Connelly Funeral Home of Essex 300 Mace AVe. Baltimore Md. 21221											
edicai Examiner	Immediate Cause (Finel disasse or condition rasulting in deeth) a. Com A With Mr TAS TRS IS Due to (or as a consequence of): Auch Of Lung (San ALC Circle) Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of):									,	2	yes.	
edicai	I that initiated eve	ents	C	Due to (o		<u> </u>		L CIELL					
edicai	resulting in dee	ents th) Last	cd		r es a consequ	uence of):				atribute to ti	he cause of death?		
r II y si cial principal	resulting in dee	ents th) Last	cd		r es a consequ	uence of):		23b. Dld t	obacco use col		he cause of death? bly 4.⊡'Unknow		
by Physician/Medical	resulting in dee	ents th) Last	cd		r es a consequ	uence of):		23b. Did to 1 1 24a. Wes perfor	obacco use cor res 2 □ No en eutopsy rmed?	3 Proba	e autopsy findings able prior to pletion of causa ath?		
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DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2, 1999 Thomas Dewey Blackistone, Jr. 3:09 PM December 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) 38457 Willow Way Road Abell St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Hours Min 10XM 20 F 213-38-0055 Yrs. 59 June 3,1940 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland St. Mary's Abell 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 38457 Willow Way 20606 U.S.A. 12. Was Decedent Ever In U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6th Waterman Seafood 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Thomas Dewey Blackistone, Sr. Mary Lillian Lathram 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Joseph Roy Blackistone (Son) P.O. Box 126, Ridge, Maryland 20680 20b. Piece of Disposition (Neme of cemetery, crematory or other piece) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Charles Memorial Gardens 12/6/99 Leonardtown, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 21. Signature of Funeral Service Licensee echaei leen Herolene. P.O. Box 270, Leonardtown, Maryland 20650 23. Part1. Enter the disease, or complications that caused the doubt. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CARDIO RESPIRATORY Immediate Cause (Final disease or condition resulting in death) Due to (or es e consequence of): CEREBRAL METASTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): LUNG CANCER Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Directo

Funeral

p

Completed

Funeral

Director

7 is marked other than "natural", or items 23s or traumstic event, the Med cal Examiner must be

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Wad cell Emerican

altimore, Maryland 21215-0020

with the Meryland

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Examine and -trensit Physician/Medical use þ Completed

> Be To

Certification:

edicai

physician ar s the burial-to funeral After n 24 hours after death e Funeral Director: / bletely filled in by the f

The law requires that the deeth certificate be executed

P.O. Box 68760,

Division of Vital Records,

or Attending Physicien:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seigure disorder

26. Piece of Death (Check only one)

Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA 28b. Time of 28c. injury at Work? 28a. Dete of Injury (Month, Dey Yeer) 5 Pending Investigation

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rurel Route Number, City or Town, State)

1 Yes 2 No

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner es stated. (Check only one) 2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

6 Could not be determined

00051738

29d. Dete signed (Month, Day, Year)

1 Yes 2 No

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

KAE THI AUNG, 24435 MERVELL DEAN RD. HOLLYWOOD, MD 20636

Registrar

31. Date filed (Month, Day, Year) ODFO 989999

25. Was cese referred to medical examiner?

1 Yes 2 No

27. Menner of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

32. Registrar's Signature

To the Hosp within 24 hos To the Fune completely fi

. 3. 3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month December 22,1999 **Physician** Catherine Florence Blackwell 9:43 a.m. /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 22680 Cedar Lane Court, Apartment 1233 St. Mary's Leonardtown 8. Dele of Birth (Month, Dey, Year) March 27,1906 Washington, DC If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1□M 2■F 578-03-2137 Yrs 93 Director Usual Residence of Decedent daath with tha Maryland 10a State 10b. County 10c. City. Town or Location 10d. fnside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mexical Examinar name be notified at St. Mary's Leonardtown Maryland 1 ■ Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 20650 22680 Cedar Lane Court, Apt. 1233 United States Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ■ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Rece - American Indian permit. Pagas 1 and 2 should be filed within 72 hours aftar a Department of Hasilth and Mental Hygiena. Department: if Itam 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exercited Pages. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Yes, Give eer or Detes: 1 ☐ Yes 2 ■ No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usuai Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper US Government 18 Mother's Name (First Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Catherine Albert John J. Hans 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 20653 19a. Informant's Name/Reletionship (Type, Print) 19479 North Snow Hill Manor Dr., Lexington Park, MD Joseph T. Jennings, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date -28-20a. Melhod of Disposition 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from Stata Arlington National Cemetery Arlington, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Se ica License Thompson? Ronald JB M01154 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Acadent /Medical Immediate Cause (Final diseese or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and the burial-transit tha death certificate be axecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): USB BSU attanding 0 ed by tha a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by t should be datach 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed' paga 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificata Hospital or Attending Physician: 24 hours after death. Funeral Director: After this carifice funaral director, 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 ■ Residence 8 Other (Specify) 2 1 ☐ Yes 2 ■ No 1 Inpalient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a, Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide

Division of Vital To the Hospital within 24 hours a To the Funeral Complately filled

6

Baltimore, Maryland 21215-0020

P.O. Box 68760

Records.

and address of person who completed caus e of death (item 23a) (Type, Print) David Allen, M.D., P.O. Box 606,

State Registrar

Medical

29a. Certifier

29b. 54

valure and title of cortifier

DEC 2 7 1999

Leonardtown, Maryland 20650 32. Registrar's Signature 31. Date filed (Month, Dey, Year)

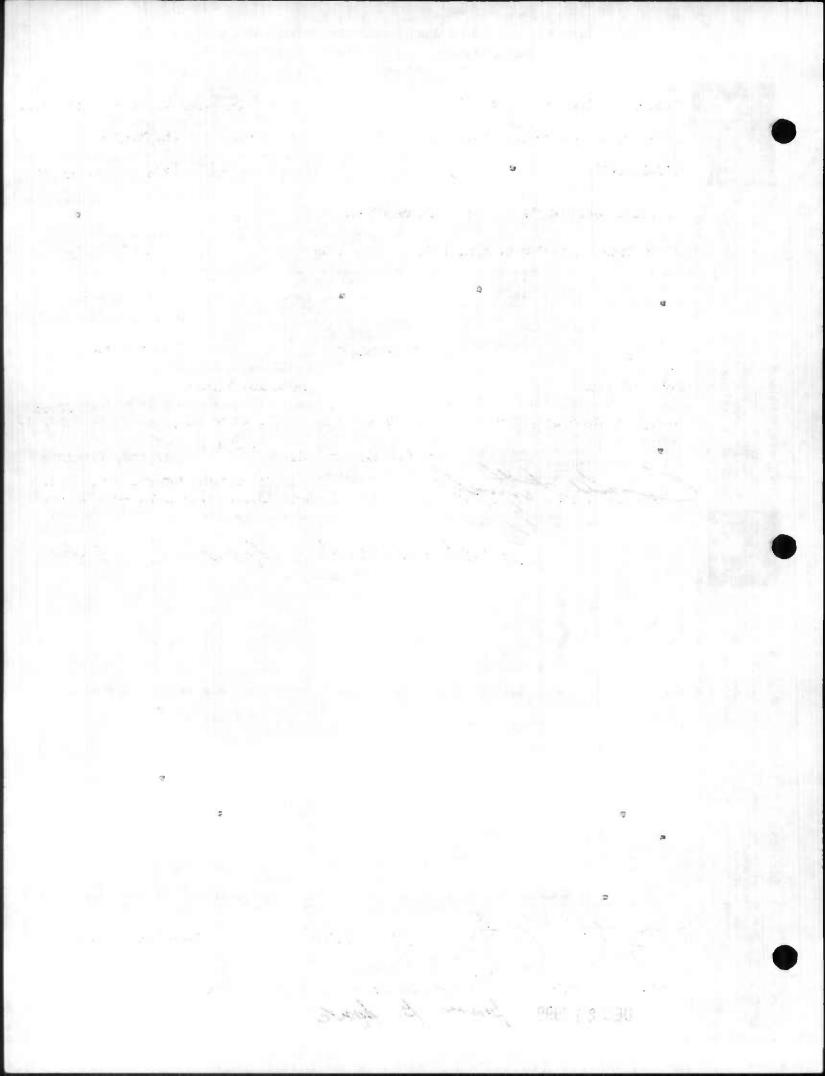
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D25230

29d. Dale signed (Month, Day, Year) December 23, 1999



permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0020

Physician

/Medical

Examiner

Funeral

Director

Hospital or Attending Physician: The law requires that the deeth certificate be assocuted Division of Vital Records, P.O. Box 68760,

219-34-6344

BARBARA BURKE

10a. Stata	10b. County		10c. City, Town o					10d. Inside City L
MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whe							1 XYes 2	
10e. Street and N				10f. Zi	Code		g. Citizen of W	het Country?
802 Fa	yette St	treet			21502	2	USA	
17 344	rried 2 Married 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 A If Yes, Give Year or Dates:	ever in U,S.	13. Wes Dece If Yes, spe	dent of Hispanic Origin? (city Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indien, Bleck, White, etc. Specify: white	
(Sp Elementary/Se	15. Decedent's Executive only highest gra		(0	ecedent's Usu live kind of wo le. DO NOT u	al Occupation ork done during most of wi se retired)	orking	6b. Kind of Bus	
12	condady (0-12)	College (1-401 5	Ret	ired	Employee	В	d of E	Education
Jack S	e (First, Middle, Last, Smith				18. Mother's Na Elean	ome (First, Middle, N Or (Wi	lmont)	
Raymor	Name/Relationship (nd Glen l				s (Street and Number or Fette Street			Stete, Zip Code) MD 21502
20a. Memod of D		Removei from State	20b. Place of D cemetery,	isposition (Na cremetory or		Dete 2	20c. Location - 0	City or Town, State
4 Donation	5 Other (Specif	y)	Rocky		eterans Co			
21. Signature of	Funeral Service Licer	1500	1//		peril Frun			
Muc	molas	2.000	upelli		erland, Ma		21502	
23a. Part1. Enter shock, or he	r the disease, or com eart failure. List only	plications that caused one cause on each lin	the death. Do not	enter the mo	de of dying, such as cardio	ec or respiretory erre	st.	Approximate Interval Betwee Onset and Dee
Immediate Caus disease or condi	tion	Metastat	ic Adeno	carcin	oma ? Primar	v Pancrea	S	Sept. 19
resulting in death	1)		Due to (or as a cor					
		b						1
Sequentially list of any, leading to cause. Enter Un	conditions, immediate		Due to (or as a cor	sequence of)				
that initiated ever	or injury nts	C	Due to (or as a con	sequence off:				
resulting in death) Last	·	200 to (01 23 2 CO	soquerios ory.				
		d						t
Part II. Other sign	nificant conditions o	ontributing to death bu	t not resulting in th	e underlying	cause given in Pert I.	23b. Did to	bacco use con	tribute to the cause of d
						1 Y	s 2 No	3 Probably 4 Uni
						24a. Wes er perform		24b. Were autopsy find available prior to completion of caus
								of death?
							s 2,2 (No	1 Yes 2 No
OE Was 4					76 Diago of D	eth (Check only on	9)	
examiner?	,	Hospital:	* ** ***	dient 200	Other		6 DO	r (Canaiba)
examiner? 1 Yes 2 27. Manner of De 1 Natural	No	28a. Date of Injur (Month, Day	nt 2 ER/Outpo y Year) 28b. Tim Inju		Other	Home 5 Reside		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Lillian May **Physician** Bullington December 20, 1999 1602 ' /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Fecility Neme (If not institution, give street end number) Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Dey. Year) If Under 1 Yeer Birthpieca (Stete or Foreign Country) 5. Sociei Security Number 7. Age (In yrs. lest birthday) **Funeral** 1□M 2/□F Deys 94 Yrs OCT. 20,1905 Director 234-07-1762 WEST VIRGINIA Usual Residence of Decedent with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner name be notified at WV 1 ☐ Yes 2 No MINERAL RIDGELEY Director 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code ROUTE 2, BOX 44 26753 permit. Pagas 1 and 2 should be filed within 72 hours efter death v Department of Health and Mental Hyghan. Important: If fear 27 is marked other than "natural", or items 23a any injury or other traumetic aname U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Meritel Stetus 1 Yes 2 No if Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: WHITE λq 3 Widowed 4 □ Divorcad Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 HOMEMAKER HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) SAMUEL DORTY McCLOUD ALBERTA B. HAMRICK 19e. informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) SONDRA ISER / NIECE ROUTE 2, BOX 44, RIDGELEY, WV 20b. Plece of Disposition (Name of cemetery, cremetery or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removei from State WHITE CHAPEL MEMORIAL CARDENS 12/23/99 BARBOURSVILLE, W 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility
UPCHURCH FUNERAL HOME, P.A. 21. Signeture of Funeral Service Licenses 202 GREENE ST., CUMBERLAND, MD 21502 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart felture. List only one cause on each line. Approximete intervel Between Onset end Deeth **Physician** /Medical immediete Ceuse (Finel disease or condition resulting in deeth) 6 days Examiner Examiner physician and the burial-trensit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence of) Physician/Medicai Due to (or es a consequence of): Pert ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Severe Osterporosis by 24b. Were autopsy findings eveileble prior to completion of cause of death? te Myozardiel infarction 24a. Wes an eutopsy performed? Completed Old C. V. A. Hournad 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28a. Dete of injury (Month, Day Year) 27. Menger of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 1 Neturei 5 Pending death. 1 ☐ Yes 2 ☐ No investigation I or Attandi after death Director: A 2 Accident 6 Could not be determined To the Hospital or Attar within 24 hours after der To the Funeral Director complately filled in by th 3 ☐ Sulcide Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Phyalcian: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sandhi, HE 47 D14464 December 21,1999 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Sikander Sandhir, M.D.- 48 Tarn Terrace, Frostburg, MD 21532 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State DEC 2 2 1999 Registrar

DHMH 16 Rev 6/95

OF C 27 19 Comment of Street,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Roseanna Boore December 22 1999 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not Institution, give street and number) Saint Vincent de Paul Nursing Center Allegany Frostburg If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) 1 M 2 F Months Days Hours Min Yrs. Maryland 06-Oct-07 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No Allegany **Mount Sayage** 10e. Street and Number 13104 Yellow Row Road, N.W. 10f. Zip Code 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, 21545-12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced White 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) manager arocery store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Thoeria **Harriet Jenkins** 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma "Peggy" Polan Daughter West Virgin 25401-Martinsburg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State \$aint George's Parish Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 27-Dec-99 Mount Savage, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility ohn Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final acute Myo Cardial infarction · Possible Ovenery Thrmbosis

Physician /Medicai Examiner

permit. Pages Department of Important: If it any Injury or o

Physician

/Medical

Examiner

213-22-2638

10a. Stete

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11. Maritel Status

Directo

Funeral

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Director

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Pages 1 and 2 should be filed within 72 hours effer death with the Maryla rent of Health and Mendal Hyglens. It fear the marked death than "natural", or frem 23a or 28a-f ahowning or other traumatic event, the Medical Examine must be notified at my or other traumatic event, the Medical Examine must be notified.

with the Maryland

Physician/Medical Examiner physician and the burial-transit ettending pl signed by the e P Completed certificate has blirector, pege 2 s director. Be

thet the death certificate be executed

law requires

The

or Attending Physician:

P.O. Box 68760,

Division of Vital Records,

Certification: To this funeral death. efter death Director: To the Hospital or At within 24 hours effer or To the Funeral Direct completely filled in by

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last

disease or condition resulting In death)

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Due to (or as a consequence of):

23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Vunknown

1 Yes 2 No

24a. Was an autopsy

24b. Were autopsy findings aveilable prior to completion of cause of death?

26. Piece of Death (Check only one) Other: 45 Nursing Home 5 Residence 8 Other (Specify)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 Suicide

4 Homicide

(Check only one)

5 Pending investigation 6 Could not be determined

28e. Date of Injury (Month, Dey Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

artiny

28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Dey, Year)

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

S. L. Sandhir, M.D., 48 Tarn Terrace, Frostburg, Maryland 21532 31. Date filed (Month, Day, Year)

State Registrar

Medical

DEC 2 8 1999

32. Registrar's Signature

9 1904 10 11 15 3 3 4 Allegner Some vincent uniform Starting Center 366-049V 10490-60 Augusted Altegrand August Sayura-AVUIT DEBOT WORK WORKS FOR CO. CT. and the Piller III Institut and resident Nomina "Pagav" Polani Edightis W. Leu La totalingfulling West Virgin 15401-

Died Emeral Hailer, 57 Host Ave., Horlburg, NO, 21,537.

Last Georges Frush Celebrates 27 (Ber. 99 - Month Son organist Assistance)

S.L. Sakeliu, M.S., 46 Terra Lemin e. Trosthown, Monylond, 21532

DEC 28 1999 Lower & Species

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00

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DEC. 27, 1999

1. Decedant's Nama (First, Middla,			Certifica	IG OI	Dealli	Reg	J. No.		
Billie	Blanche	В	arkley			2. Data of Deeth Month Dec 26	Day 199	3. Time of 01:45	
4e Facility Nema (If not institution, Allegany Coun				(4b. City, Town, or I Cumberla	and		of Death Allegany	
220-10-0523	5. Sax 7. A 1 ☐ M 2 1 F	ga (In yrs. lasi 78	Diff friday)	ar 1 Year Deys		8. Dete of Birth Jan 22,	^{(ear} 1921	9. Birthplece (Stata of Country)	or Foreign
10a. Stata 10b. County		10c. City, 7		1	<u>.</u>			10d. Insida Ci	
10e. Street and Number						10g. Citizen of What Country?			
11. Marital Status	12. Was Decedan Armed Forces d 1 Yas 2	No No			Hispenic Origin? (S ean, Maxican, Puart	pecify Yes or No- o Rican, atc.)	14. Race Black	, White, etc.	
	greda completed)	5+)	(Giva kind of w lifa. DO NOT	ork dona usa ratire	pation during most of wor ed)	king			
)	
1 Burial 2 Cremation 3 4 Donation 5 Other (Spe 21. Signature of Funeral Service Li 23a. Part 1. Enter the disease, or a shock, or heart failure. List or Immediata Cause (Final disease or condition	complications that causily one cause on each	Rest	lawn Me Scarr Cumb	mor: perioda of dy	ial Gard In Frunciand, Maing, such as cardiac	d12/29 L cal Home cyland	aVale P.A. 21502	Approximat Interval Bat Onsat and	ta wean Deeth
Sequantially list conditions, if eny, leading to immediate causa. Enlar Undarlying Causa (Disaasa or injury that initiated avants resulting in death) Lest									
Pert II. Other algniflcant condition				causa gi	van in Part I.			tribute to the cause 3 Probably 4	
								24b. Were eutopsy available prior completion of co of death?	to
25. Was case referred to medicat axeminar? 1 Yas	Hospital: 1 ☐ Inpa	ient 2 TEC	/Outpatiant 3□ [Ot Ot	her)	1 □ Yes 2 🖟	No
27. Mannar of Death 1 Netural 5 Pending	28a. Data of In (Month, E	jury 28	b. Time of Injury	28c. Inju		28d. Dascribe how			
	Usual Rasidance of Decedant 10a. Stata Usual Rasidance of Decedant 10a. Stata 10b. County MD All 10e. Street and Number 4 Browning St 11. Marital Status 1 Navar Marriad 15. Decedant's (Specify only highast Elementery/Secondery (0-12) 17. Fathar's Nama (First, Middla, La Robert O. Moc 19a. Informant's Name/Ralationshidelicie Pender 20a. Method of Disposition 18 Burial 2 Cremation 3 4 Donation 5 Othar (Specific Councilla) 21. Signature of Funeral Service Life in Signature of Funeral Service Life in Serv	Usual Rasidance of Decedant 10a. Stata 10b. County 10c. Street 10b. County 10c. Street and Number 4 Browning Street 11. Marital Status 12. Was Decedant 174	Usual Rasidance of Decedant 10a. Stata 10b. County MD Allegany 10c. City, T MD Allegany 11c. Was Decedant Evar in U.S. Armed Forces, and Forces, a	Usual Residance of Decedant 10e. State 10b. County MD Allegany Cumber 10c. City, Town or Location MD Allegany Cumber 10c. Street and Number 4 Browning Street 11. Marital Status 1 □ Navar Marriad 1 □ Navar Decedant's Luc Marriad 1 □ Navar Dece	Usual Rasidance of Decedant	Usual Rasidance of Decedant 10. County 10. City, Town or Location 10. Stata 10. County 10. City, Town or Location 10. Stata 10. County 10. City, Town or Location 10. City Loc	Usual Residence of Decedant 10a. State 10b. County 10c. City, Town or Location 10b. Street and Number 4 Browning Street 10b. Zip Coda 10d. Zip	220-10-0523 10 M 3/F 78 Vrs. Months Deys Hours Min. Jan Jan	Usual Passidance of Decedant Usual D

State Registrar

DEC 2 8 1999

31. Data filed (Month, Day, Year)

30. Nama and addrass of person who completed causa of deeth (Item 23e) (Type, Print)

Robustiano J. Barrera, M.D.; Memorial Hosp. Med Bldg; Cumberland, MD 21502

D-14865

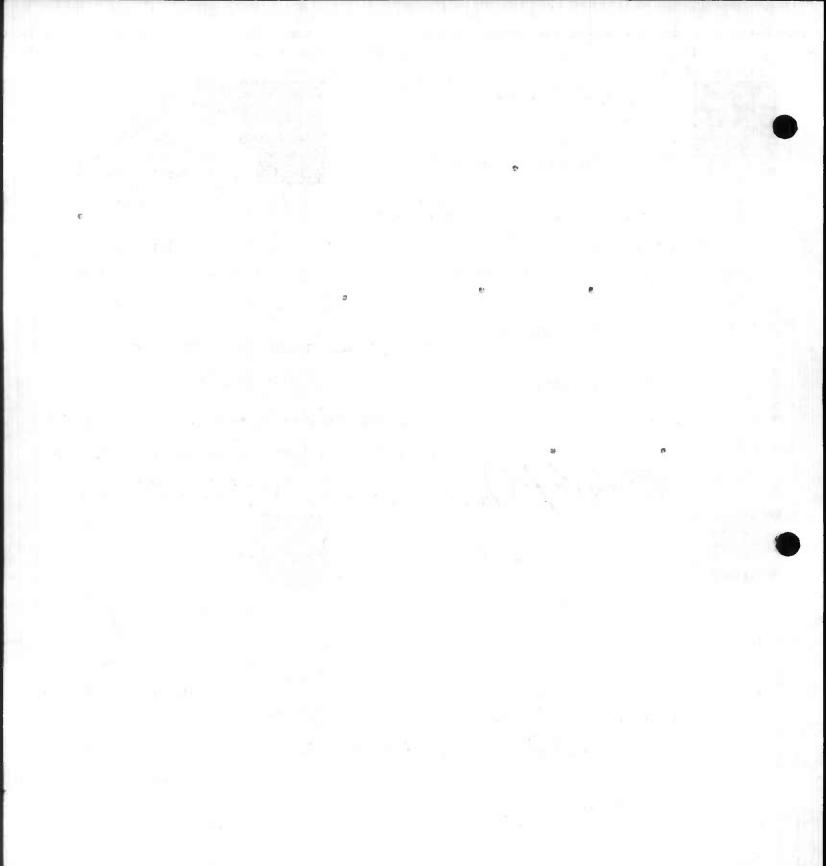
TO SER HER STATE OF THE SERVICE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene QQ

						Cei	rtificate	of D	eath			Reg. No.	**	71007
	Physic /Medi		1. Decedent's Neme (First, Middle, L Edith Juanita		t						2. Dete of D Month DECEM	Day	Yeer 1999	3. Time of Death 10:36PM
	Exami		4a. Fecility Neme (If not institution, git St. Mary's Hospit		nber)	-			. City, Tow		ocation of Dee		y of Deeth Mary	
	Funeral Director		410-09-8641	Sex 1□M 2■F	7. Age (In yrs. Ia 86	rst birthday) Yrs.	If Under 1 \ Months D	/ear /eys	If Under 2 Hours	Min.	8. Date of B (Month, D August	tth ey, Year) 2,1913	9. Birthi Cour Tenr	plece (State or Foreign ntry) IESSEE
	Menyland a-f ahow	tor	Usuel Residence of Decedent 10a. Stete 10b. County Tennessee Washing	gton		Town or Lo								10d. Inside City Limits 1 ■ Yes 2 □ No
	ath with the	Funeral Director	10e. Street end Number 1721 Skyline Driv	<i>7</i> e		10f. Zip Code 37604						10g. Citizen of United	ntry? Ces	
5-0020 72 hours after death with the Menyland netural; or items 23a or 28a-f ahow sical Examiner must be notified at	þ	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1 Tes If Yes, Give Year or Da	2 No		13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2 ■ No Specify: Specify: ₩						ck, White,	etc.	
21215-0020		Completed	15. Decedent's E (Specify only highest gi Elementary/Secondery (0-12)	Education rede com <i>pleted)</i> College (1-	-4or 5+)	(Give	dent's Usual C kind of work of DO NOT use r Ig Depa	fone du etired)	inng most	of worki	ector	16b. Kind of B		dustry ach Company
Maryland	permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiens. Important: If Item 27 is marked other than 'any Injury or other traumatic event, the Mans.	To Be	17. Fether's Neme (First, Middle, Las David Nelson Card	•							ittakei	e, Meiden Sumer	ne)	
	and 2 sho ealth end n 27 is m		19e. Informant's Name/Relationship Lee Ervin, Son	(Type, Print)		5212	Farm S	tat:				elley Ci		Code) Jtah 84120
Baltimore,	Peges 1 ment of Hi ant: If Itan ury or oth		20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Spec		State Mont	aca of Dispo metery, crer Ce Vis	netory or othe ta Bur	of r plece) ial	Park	1	2-10-9	20c. Location Tohnson		
Balt	permit. Departimont. any inj		21. Supplies Funeral Service of Edward N. Brit	VI	Jr.,M000	052 22	2. Name end A	ddress	of Fecility	Bri	nsfield	d Funera	1 Hon	ne, P.A. 20650-0279
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Finel disease or condition resulting in death)	Contract of the Contract of th	used the death.	Do not ent	er the mode o	f dylng,	such as c	cardiac o	or respiretory			Approximete Interval Between Onset and Deeth
Box 68760,	eath certificete be executed attending physician and for use es the burial-transit	an/Medical Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b		es e consec as a conseq								
P.O. B	that the death cert ed by the attendin detached for use	hysicia	Pert II. Other significant conditione	contributing to de	ath but not resul	ting in the u	nderlying caus	e given	n in Pert I.	1.		Yes 2	ontribute to	o the cause of death?
Records, F	requires been sign should be	Completed by Physician	Ahred fibrill	later S	, d	uli	for M	elle	tus	9	24e. We	s en eutopsy ormed?	ev	fere eutopsy findings relieble prior to impletion of cause deeth?
al Re	sician: The law certificate hes b director, page 2 s		0								1 🗆	Yes 2		Yes 20No
Vital	Physician: rthis certific rral director,	To Be	25. Was case referred to medical examiner?	Hospitel:	npatient 2 ☐ E	R/Outpetier	nt 3 DOA	Other			Check only	one) ildenca 6 □Otl	har (Cnasi	6.1
n of	ng Phys fter this uneral di		27. Menner of Deeth 1. ☐ Naturel 5 ☐ Pending	28a. Dete o		28b. Time of Injury		Injury e Work?				how injury occur		(9)
Division	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not 1 4 Homicide determined	28e. Pleca	of Injury - At hong, etc. (Specify)	ne, farm, str	M eet, fectory, o		es 2□N			(Street end Num own, Stete)	ber or Run	el Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai C	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exe	hysician: To the t miner: On the ba	sis of exemination	ledge, deeth on and/or in	occurred et t vestigetion, in	he time my opir	, date end nion, deeth	plece, o	end due to the ed et the time	ceuse(s) end m , dete end placa,	enner es s end due t	steted. o the ceuse(s)
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			DR. JAMES C	BOYD	CALIFO	, . ,	,	206	519			· ·		
	Sta Registi		31. Dete filed worth, Dey, Year) DEC - 7 1	999 32. Re	gietrer's Signetu	Je J	Low	uk.	2					

EDITH JUANITA CORNETT



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physiclan** James Gibbon Campbell DECEMBER 05, 1999 9:02PM /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** St. Mary's Hospital Leonardtown St. Mary's 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) December 22, 1932 Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1■ M 2□ F 214-28-4407 66 Yrs Director Maryland Usuel Residence of Decedent the Maryland 10a Stete 10c. City, Town or Location 10d. Inside City Limits e filed within 72 hours effer death with the Marylar al Hygiene.

al Hygiene Han "naturel", or freme 23s or 28s-f show vent, the Modical Examiner must be notified at Maryland St. Mary's Ridge 1 ☐ Yes 2 ■ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 48588 Wynne Road 20680 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien Bleck, White, etc. 1 ☐ Yes 2 ■ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 21215-0020 Specify: Black 1 ☐ Yes 2 ■ No Specify: þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondery (0-12) College (1-4or 5+) Laborer Electric Utility 8 . Pages 1 end 2 should be filed v tment of Health end Mental Hygie tant: If Item 27 Is marked other ti lury or other traumatic event, In Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be John Mansel Campbell Lillian Jones 19e. Informent's Neme/Relationship Type, Print 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Marion C. Campbell, Wife 48588 Wynne Road, Ridge, Maryland 20680 20b. Plece of Disposition (Neme of 20a. Method of Disposition 20c. Location - City or Town, State Metropolitan Crematory 1 ☐ Burial 2 ■ Cremetion 3 ☐ Removal from State 12-7-99 Alexandria, Virginia Depertment of Important: If any injury or 4 ☐ Donafon 5 ☐ Other (Specify) 22. Name end Address of Fecility Brinsfield Funeral Home, P.A. hael K. Blankenship, M00857 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Pert1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Onset end Deeth **Physician** Embolus /Medical immediate Ceuse (Final disease or condition resulting In death) Examiner Due to (or es e consequence of): Examiner Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest Due to (or es e consequence of): physician s the buriel Box 68760, Physician/Medical Due to (or es e consequence of) P.O. 23b. Did tobacco use contribute to the cause of death? Pert tl. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Completed by Records, 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1□Yes 2 Vital funeral director, 25. Wes case referred to medical exeminer? 26. Piece of Deeth (Check only one) 1 Yes 2 Hospitat: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) of Medical Certification: To 3 ER/Outpetient 3□ DOA this 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. tnjury et Work? After 5 Pending investigation 1 Naturat 2 Accident Division Hospital or Attending efter death. 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide within 24 hours e To the Funeral C Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 | Medical Examiner: On the desis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29b. Signeture and title of annihier 29d. Date signed (Month, Dey, Year) D19917 30. Name and address of port use of death (item 23a) (Type, Print) JAMES/ C. BOYD CALIFORNIA, MD. 20619

State

Registrar

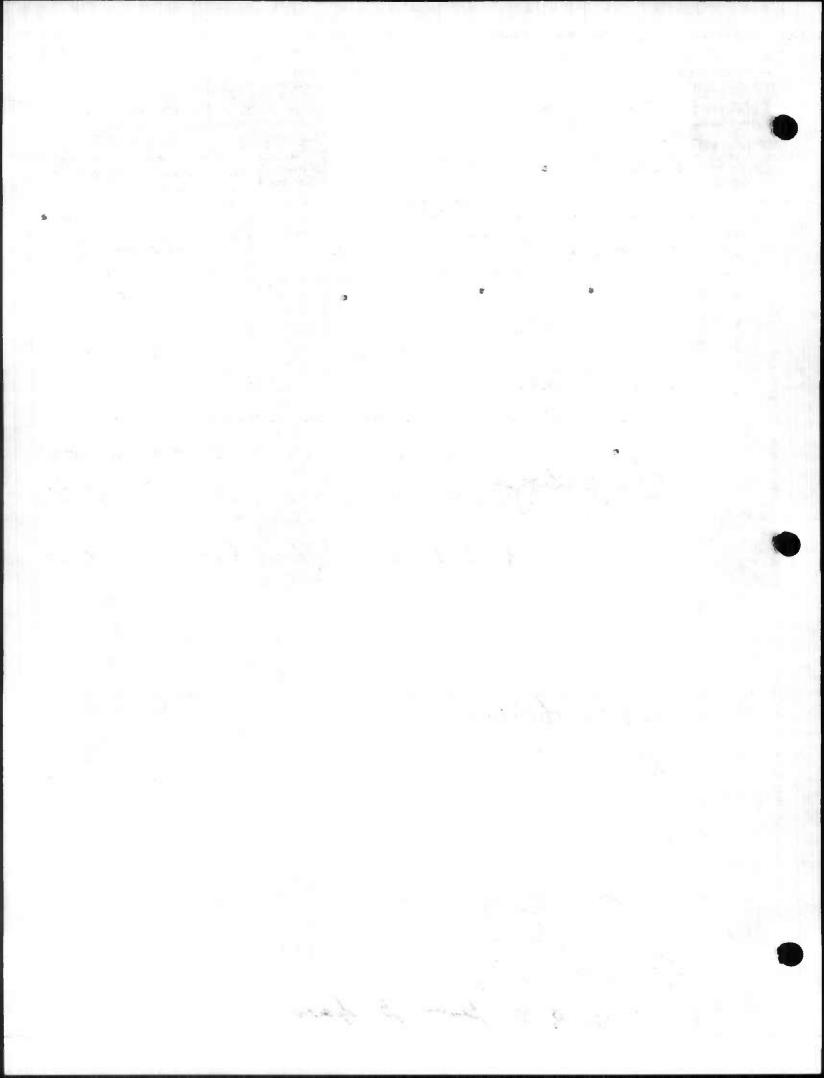
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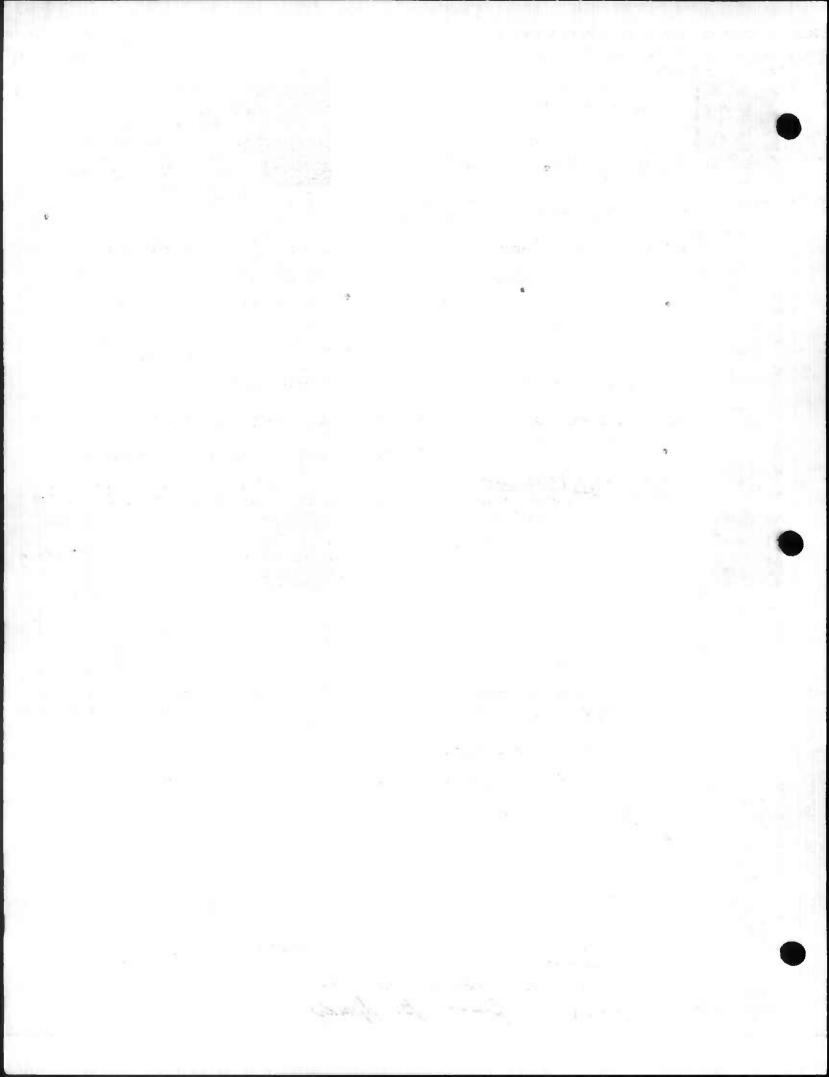
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GIBBON CAMPBELI

JAMES



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_	Physic /Medi		Halvor Leman Can	ter					Month DECEMB	ER 05, 1	Yeer 1999	5:25PM	
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Т	Funeral		Social Security Number 6. Security Number	144	lest birthday)	if Under Months	1 Year Deys	if Under 24 Hrs Hours Min	8. Dete of Bir	h v Year)	9. Birth	plece (State or Foreign http) Land	
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	ne 23a	Funeral	11. Marital Status	12. Wes Decedent Ever in U	.S. 13. V	Vas Deced	ent of H	lispanic Origin? (9	Specify Yes or No	14. Rec	a - Ameri	can Indien,	
0	rs after deal	F	1 Never Married 2 Married	Armed Forces? If Yes, spe			ify Cuba	an, Mexican, Pue	to Rican, etc.)		ck, White,		
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pu	tal Hygi d other	Be	17. Fether's Neme (First, Middle, Last) Robert Edward Cant	er					me <i>(First, Middl</i> e, Hunter	Maiden Sumen	10)		
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Ba	permit. Pagas Depertment of Important: If it any Injury or once.		MIMIKSW	42		. Name end	u Addre	ss of Fecility Br	insfield	Funera	l Hon	ne, P.A.	
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2	Physician /Medicai		Immediate Ceuse (Final	m No	, , ,	1000	. 0	11-	, /				
	Examiner		disease or condition resulting in death)	- (P) IVE	n 1	erc	m	Neger ciden	167		1	3-4 day	
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S	daath. ctor: A y tha fu	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	ome, farm, stre				28f. Location (Street end Numb	er or Run	al Route Number,	
Ö	after after Dire	Certification:	4 ☐ Homicide	building, etc. (Specify	y)	,			City or To	vn, State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A complataly filled in by tha t	aic		Iclan: To the best of my kno									
	n 24 n 24 ne Fu	edicai	(Check only 2 Medical Examir one)	er: On the basis of examine end menner steted.	tion end/or inv	restigetion,	in my o	pinion, deeth occ	urred et the time,	dete end plece,	end due t	o the cause(s)	
	withi To the	Σ	29b. Signeture end title of certifier			29c		e number		29d. Dete signe	d (Month,	Day, Year)	
			Donew				()	3620	6	12/8	99		
			30. Neme end eddress of person who co	mpleted cause of deeth (Item	23e) (Type, I	Print)					-		
			DR. KIRAN D. MEI		WOOD,	MD. 2	0636	6					
	Sta		31. Dete filed (Month, Day, Year)	32. Redistrer's Signe	ture &	1	ack	4					
	Registr	ar	DEC - 9 199	7	1	19							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Day Yee Month **Physician** Playford Leroy Cover 14, 1999 22:15 December /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Cumber 1 and 8. Dete of Birth (Month, Day, Year) NOV 26, 1930 Memorial Hospital Allegany If Under 1 Year Birthplace (State or Foreign County) MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 10M 20F 69 Yrs 220-28-9324 Director Usual Rasidanca of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Mineral 28a-f Ridgeley 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or P.O. Box 674 26753 USA Funeral Neme 2 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien, 11 Marital Status Bleck, White, etc. r than "natural", or han filed within 72 hours after 1 Never Merried 2 Married 1 Yes 2 □ No Specify: Specify: white py 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry / Hygiene. Elementary/Secondary (0-12) Cottege (1-4or 5+) Clerk Railroad 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Pages 1 and 2 should be nent of Health and Mental Stanley Cover Luveda (Boggs) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) P.O. Box 674; Ridgeley WV 26753 19a. Informent's Neme/Relationship (Type, Print) Barbara V. Cover P.O. Box 674; Ridgeley or other traces or or other traces 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 1 Qurial 2 Cramation 3 Removel from Stete 4 □ Donetion 5 □ Other (Specify) Sunset Memorial Park 12/17 Cumberland, MD me of Funeral Sellvice Licens 22 Scarber 1 Funeral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset and Deeth **Physician** /Medical Immediate Cause (Finat disease or condition rasulting in death) a Cholangitis 4 weeks Examiner Due to (or es a consequence of): Examiner b. Adenocarcinoma Pancreas 1999 Jan. the bunal-trensit Sequentially tist conditions, if any, laading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events rasulting in death) Last Due to (or as a consequence of): or Attending Physician: The lew requires that the deeth certificate be execu Physician/Medical Due to (or es a consequence of): signed by the attending the detached for use 23b. Did tobacco use contributa to the cause of death? Pert tt. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? pege 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No this certificate 25. Wes casa raferred to medical axaminer? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident 6 Could not be determined 28a. Placa of Injury - At home, ferm, street, factory, office building, atc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical

Es

Dr. Qamar U. Zaman

29c. License number 29d. Date signed (Month, Day, Year)

December 21, 1999

30. Name and eddrass of person who completed cause of deeth (Item 23a) (Type, Print)

Johnson Heights Medical Bldg. 625 Kent Ave. Cumberland, MD 21502

31. Dete filed (Month, Dey, Year) State DEC 2 2 1999 Registrar

(Check only one)

29b. Signeture and tills of certifier

32. Registrar's Signature

D0023371

Within 2 ŝ

Baltimore, Maryland 21215-0020

220-28-9324

Division of Vital Records.

Playford Cover

bearing the sprache

PER 22 331

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Joseph Jerome Connors December 21, 1999 5:10 am 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Allegany Memorial Hospital Cumberland H I Inder 1 Vear 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Months Days Hours 1X M 2□ F 215-01-2515 Yrs 79 Jan 17, 1920 Maryland Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD Garrett Grantsville 10e Street and Number 10f Zip Code 10g. Citizen of What Country? 187 Hemlock Loop 21536 USA 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Yes 2 □ No If Yas, Giva 1 Nevar Marriad 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced Yaar or Datas: 1944-46 white 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Photoengraver Alcoa-Gravure Co. 18. Mother's Neme (First, Middle, Maiden Sumame) Joseph Connors Margaret Selder 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Trowbridge/daughter 1005 Quaker Ridge Ct., Oviedo, FL 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata MD Veteran's Cem. 4 ☐ Donation 5 ☐ Other (Specify) Flintstone, MD Dec 23, 1999 21. Signeture of Funeral Service Licensee 22. Nama and Address of Facility Newman Funeral Homes, P.A., PO Box 275 23a. Part1. Entor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or many failure. List only one cause on each line. ewman Approximete Interval Between Onset and Death Immediate Cause (Finel disease or condition rasulting in death) 11 days a Sepsis with renal failure Due to (or as a consequence of): Streptococcus bovis endocarditis 11 days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 28 No 3 Probably 4 Unknown Myocardial Infarction, Splenomegaly 24b. Were sutopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2₽No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 1.☑Inpatiant 2 ER/Outpatient 3 DOA 27. Menner of Death 28b. Time of Injury 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physician /Medical Examiner

permit. Pege Department of Important: If any Injury or pace.

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23s or 28s-f show idical Examiner must be notified at

Peges 1 and 2 should be filed within 72 hours after nent of Heelth and Mental thygiene.

wit: if item 27 Is marked other than "natural", or item inty or other traumatic event, the Medical Empirer in yor other traumatic event, the Medical Empirer.

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records.

Division of Vital

Director

Funeral

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Completed

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death with

Examiner sician and burial-transit physician s the burial signed be del page 2 s this funeral After

The law requires that the death certificate be assecuted death.

Physician/Medical þ Completed Be

Medical Certification: To or Attending 24 hours after deat Funeral Director: filled in by Hospital within 24 had To the Fune completely fi 2 (18) my.

29e. Certifier 29b. Signatura and titla of certifian

31. Date filed (Month, Dey, Year) State DEC 23 1999 Registrar

4 Homicide

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Boyd Sprenkle, Memorial Hospital, Cumberland, MD

32. Registrar's Signature

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

pach

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

D54946

29d. Date signed (Month, Day, Year)

December 2(, 1999

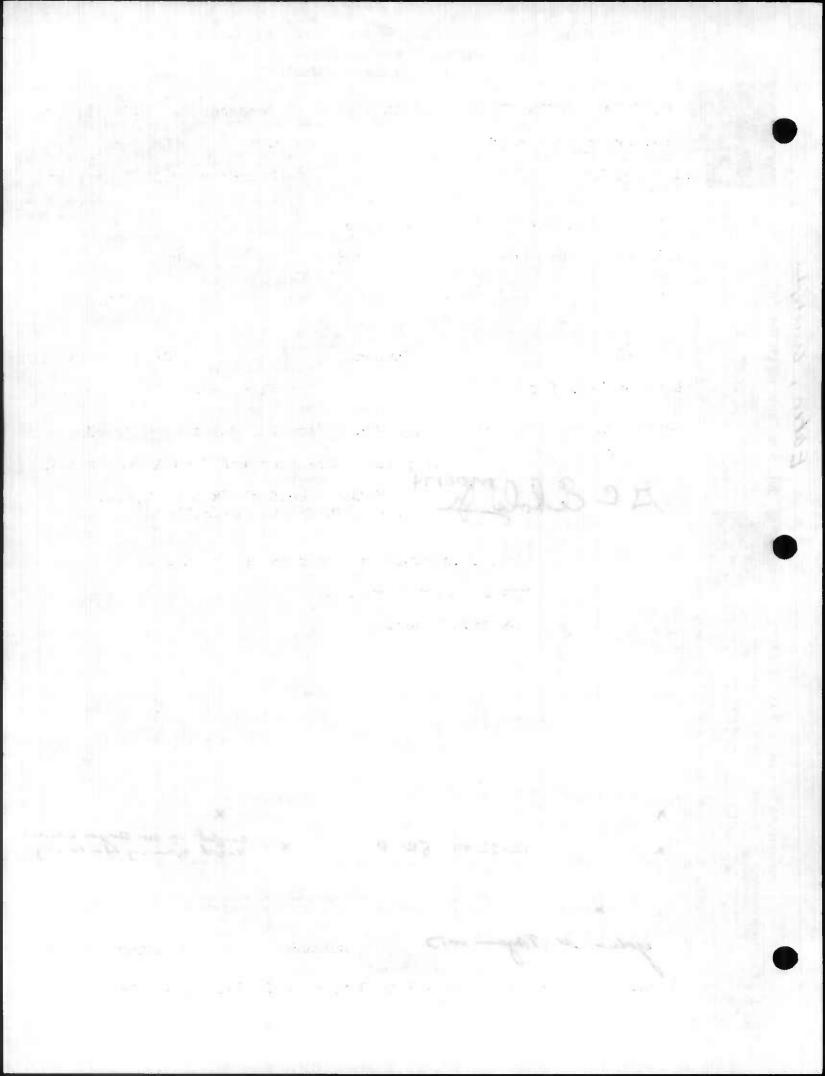
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Physician	1. Decedent's Neme (First, Middle, Last)		2. Date of Death Month		3. Time of Death				
· /Medical	MATTHEW CHRISTOPHER EATON		ecember		99 5:07PM				
Examiner	4e Fecility Name (If not Institution, give street and number)		or Location of Death	4c. County o					
	8155 Greer Farm Road	Welcon or 1 Yeer If Under 24 F		Char					
Funeral Director	218-21-5425 18 M 2 F 17 Yrs. Months	Days Hours M	in. (Month, Dey,	Yeer) 10,1982	Birthplece (Stete or Foreig Country) Maryland				
ahow I	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		- 15		10d. Inside City Limits				
with the Maryland a or 28a-f show the notified at	MD Charles Welcom	e p Code	10	1 ☐ Yes 2 🔀					
23a or		0693		at oodiniy.					
or hems		edent of Hispenic Origin? ecify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	Black	- American Indian, , White, etc. White				
natural', ideal Exil	15 Decedent's Education 16a Decedent's Usu	uel Occupetion		16b. Kind of Bus	iness/Industry				
	(Specify only highest grede completed) Elementery/Secondery (0-12) 11 College (1-4or 5+) Studen	ork done during most of use retired)	vorking	High	School				
d other	17. Father's Name (First, Middle, Last)		leme (First, Middle, A	Maiden Sumeme)				
marked or umatic eve	Gary Michael Eaton	Christ	tina Mari	ie Gree	er Eaton				
raum raum		s (Street and Number or	Rurel Route Number,	, City or Town, S	Stete, Zip Code)				
\$ = \$	Christina Eaton/Mother 20a. Method of Disposition 1 Burlal 2 A Cremetion 3 Removal from State	other place)							
Departman Important: any injury once.	4 Donation 5 Other (Specify) Metropolita 21. Signature of Funeral Service Sicence O 174 22. Name a	n Cremato: Ind Address of Fecility	cy12/28/9	99 Alex	kandria,VA				
any ir	ARFHA	RT-FCHOIS	FUNERAL	HOME.	P.A.				
	23a. Part1. Enter the disease, or complications that caused be death. Do not enter the moshock, or heart failure. List only one ceuse on each line.	BOXying, 567 es Lat	Ac PLATA	MD 2064	Approximate interval Between				
ysician fedical aminer	Immediate Cause (Final disease or condition resulting in deeth) • Multiple compound Due to (or as a consequence of upper /lower Limps	fracture			Onset end Deeth				
trans									
d by the ettending physician and leteched for use as the bunet-transit Physician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): massive bleeding c. Due to (or es e consequence of):								
or usa as tha burior usa as the control of the control	d								
the eff hed fo	Part tt. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part t.	23b. Did to	bacco uss con	tribute to the ceues of death				
y Phy			1 □ Y:	3 Probably 4 Unknow					
page 2 should be deteched page 2 should be deteched Completed by Physic			24a. Wes e perform	n autopsy ned?	24b. Were eutopsy findings eveilable prior to completion of ceuse of death?				
s certificate has director, paga 2 To Be Comp			1 □ Ye	es 2 No	1 ☐ Yes 2 ☐ No				
Be Be	25. Was case referred to medical examiner?		Deeth (Check only on	(0)					
	1 2 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 D C 27. Manner of Deeth 28a. Date of Injury 28b. Time of		g Home 5 Reside						
After	27. Manner of Deeth 1 □ Naturat 2 ☒ Accident 3 □ Suicide 4 □ Homicide 28. Date of Injury (Month, Dey Year) 12 - 22 - 94 28e. Placa of Injury - At home, farm, street, facto building, efc. (Specify)	28c. Injury at Work? 1 □ Yes 2 ☑ No	Keept	Spain.					
To the Funeral Director: completely filled in by the Medical Certificat	29a. Certifier (Check only one) 1 Certifying Physicien: To the best of my knowledge, deeth occurred and manner stated.								
Nec Me	29b. Signeture and title of certifier	9c. License number	2	9d. Date signed	(Month, Dey, Year)				
	yelin M. TAyann M.	D0050883		Decemb	er 22,1999				
State Registrar	30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Yahia M. Tagouri, MD 111655 Wine Sa 31. Dete filed (Month, Day, Year) DEC 27 1999 32. Registrar's Signature	app Lane I	a Plata,	MD 206	546				



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	_			Marylar				ealth and Death		Reg. No.	9 4	1660	
Physic /Med		Decedent's Name (First, Middle, La NELLIE CATHERIN							2. Date of I Month DECENE	Day	Year	3. Time of Death 3:05 PM	
Exam		4a Facility Name (If not institution, give	r Location of De		y of Death								
		THE CHATEAU OF						CUMBERI			EGANY		
Funera Directo		217 10 1100	Sex 7. I□M 2只F	Admetted David Marine A					rs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Fore Country) MARCH 28 1918 MARYLAND				
D s		Usual Residence of Decedent 10s. State 10b. County		100 Ci	ty, Town or Loc	ation					104	Inside City Limits	
aho	7	MARYLAND ALLEGA	NV		JMBERLA							1 Yes 2 No	
the N	Director	10e. Street and Number	71/ 1	- 00	TIDEKLA		Code			10g. Citizen of		**	
deeth with the Maryland rms 23a or 28a-f ahow ir maist be notified at		14914 GRADY DRIV	E S.E.	101. Zip Code 21502						U.S.A		r	
_ 5 22	y Funeral	11. Marital Status 1 Never Married 2 Married	12. Wes Decede Armed Force 1 Yes 2 If Yes, Give	s? ∑iNo	If	/as Deced Yes, spec	cify Cuba	ispanic Origin? (n, Mexican, Pue Specify:	Specify Yes or I into Rican, etc.)	Bla	ce - American ack, White, etc.		
72 hours	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Date	S:							WHITE		
21215-0020 d within 72 hours af glona. rr than "natural", or , or the ficial from	Completed	15. Decedent's Elementary/Secondary (0-12) 1 2	ducation ade completed) College (1-4d	or 5+)	16a. Deced (Give I life. D	cind of wo O NOT u	rk done d se retired	during most of wi)	orking	LAUND	Business/Indus	lny	
	Ö	17. Father's Name (First, Middle, Last)		OKISIA	L LA	MDK		ame (First, Midd	lle, Maiden Suma			
Maryland d 2 should be flig th end Mentel Hy 7 le marked oth treumatic event	To Be	CLAUDE WAGNER SR						DAISY	LEWIS				
Mary d 2 shou th end N 7 is mar treument	-	19a. Informant's Name/Relationship (Type, Print)		19b. Meilin	g Address	(Street	and Number or F	Rural Route Nun	nber, City or Town	n, State, Zip Co	ide)	
~ 5907		CARRIE O. PLATT		SISTER	1240	O CRO	OSS I	ROAD COU	RT CUMB	ERLAND M	ARYLAN	D 21502	
		20a. Method of Disposition	Domeral from Sta	1	Place of Dispos cemetery, crem	ition (Nar	ne of ther plac	e)	Date	20c. Location	- City or Town	, State	
Pege nento ury or		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		DAV	IS CEM	ETERY	DE	CEMBER 2	4 1999	CUMBERI	AND MA	RYLAND	
Baltimo pemii. Pege Department of Important: If I any Injury or		21 Signature of Funeral Service Licer	Mount	ر ا				S of Facility DAMS FUN		ME P.A.	RYI.AND		
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caus	sed the deat							. Ac	oproximate terval Between	
Physician		arous, or real failure. Los only	One Cause on each	i iiio.								nset and Death	
/Medical Examiner		Immediate Cause (Final disease or condition	4	0	huses	-des	i	· ~ 1 - =	Z.		en	merlen i.	
Examine	1.7	resulting in death)	a	Due to (d	Due to (or as a consequence of):								
D #	Examiner		b	Isa	remi	con	des	myem	ity		5	ye	
60, be assecut lelan and buriel-tran	Хөп	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or es e consequence of):									
68760, cata be assected physician and the burlei-transit	Cal	cause. Enter Underlying Cause (Disease or injury that initiated events	attersclentin Condervorando						à le	ey			
	- 등	resulting in death) Last	Due to (or as a consequence of):								1		
Geeth certification of for use as	8	d											
To and a point	C	Dart II Other else ifferest conditions of	ontributing to death but not resulting in the underlying cause given in Part I.						non D	23b. Did tobacco use contribute to the cause of death			
0 \$ 55	Physician/Me	Part II. Other arginiticant continuous c	ontributing to deatr	DUT NOT 18S	uiting in the un	denying c	ause give	en in Part I.		U Yes 22TNo		e cause or death r	
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COTO requir	Completed t									as an autopsy rformed?	availa	autopsy findings ble prior to letion of cause ath?	
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of Vita Physicien: this cartific ral director,	To B	examiner? 1 Yes 25 No	Hospital:	itient 2 🗆	ER/Outpatient	3 DC	OA Oth	er		sidence 6 🗆 Ot	her (Specify)		
g Physical distriction		27. Manner of Death	28a. Date of Ir (Month, I		28b. Time of Injury	2	8c. Injun Worl	at	28d. Describ	e how injury occu	rred		
VISION Attending r death. Ector: After by the fune	atic	2 ☐ Accident investigation	n	,	a your	М		Yes 2 □ No					
Division of or Attending Physaffer death. Director: After this	Certification:	3 ☐ Suicide 6 ☐ Could not b determined	288. Place of	Injury - At he	ome, farm, stre	et, factory	, office			(Street and Num Town, State)	ber or Rural R	oute Number,	
Hosp 4 hou Fune	edical	(Check only 2 Medical Exam	ysician: To the besinner: On the basis	of examina	wiedge, deeth	occurred estigetion	at the tim	ne, date and place oinion, death occ	e, and due to the	e, date and place	anner as state, and due to the	id. e cause(s)	
DIVISION OF To the Hospital or Atlanding Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Med	29b. Signature and title of certifier	and manner	stated.				number		29d. Date sign			
LAK 8	, -	200. Signature and title of certifier	11 3				D 17			DECEMBE!			
" c	,	6(1)0	llno h				ע די	707		DECERBE	. 22, 1	797	
	6	30. Name and address of person who	completed cause o	death (Iten							-00		
0.	oto	DR. ANTHONY J. BO 31. Date filed (Month, Day, Year)	OLLINO JR	. 922 strar's Signa	NATION	AL H	1GHW	AY LAVA	LE MARY	LAND 21	502		
Regist	ate rar	DEO 0 0 4-	199	ener	1 4	1	70. 4	,					

DHMH 16 Rev 6/95

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traumatic event, the Medical Examiner must be notified at

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mit. Pages 1 end 2 should be file spartment of Health end Mentel Hy portant: If item 27 is marked oth ly injury or other traumatic event

permit. Page Department of Important: If any injury or once.

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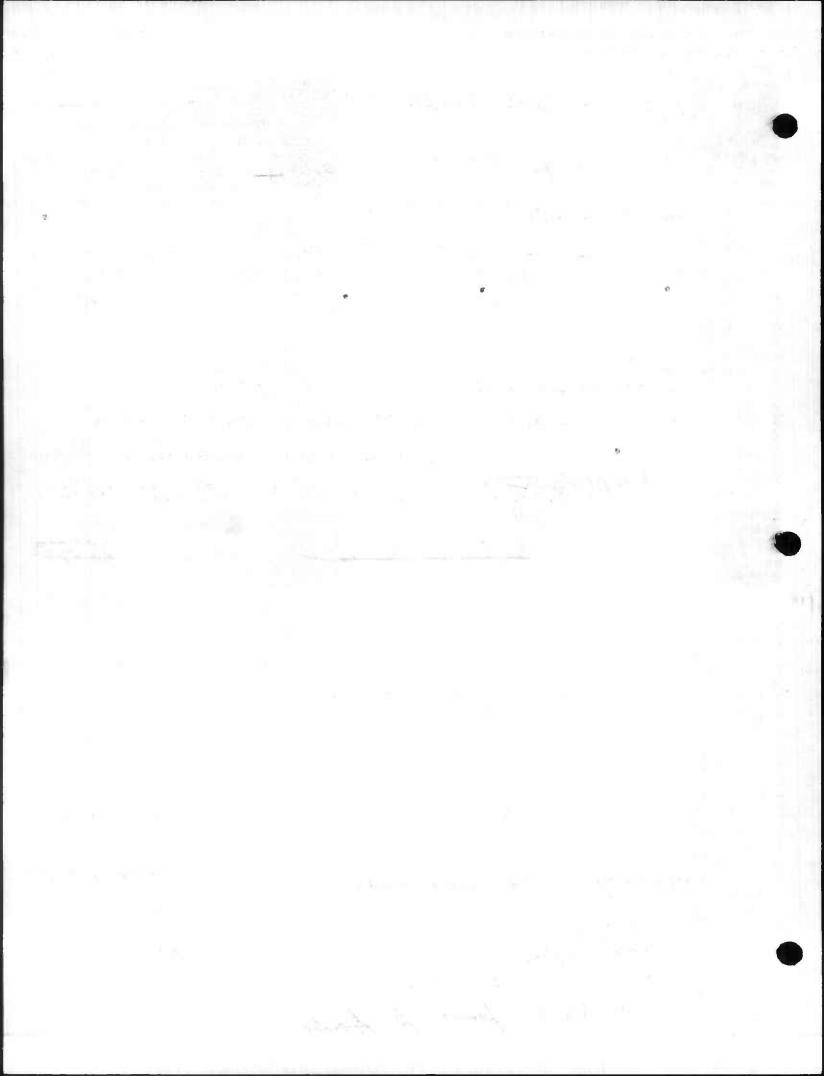
Baltimore, Maryland

FEBUS

i or Attending Physician: 'efter death.'
Director: After this certifica funerai Certification: 1 Natural 2 Accident the 3 Suicide Š 4 Homicide To the Hospital or A within 24 hours effer To the Funeral Dire completely filled in b DECIVERY PREMATU ROOM 29a. Certifier Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner steted. Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) D46846 30. Name and eddress of person wife completed cause of deeth (Item 23e) (Type, Print) HOLLYWOOD, MD. 20636 FAHMI FAHMI 31. Dete filed (Month, Dey, Year)

DEC 1 (32. Registrer's Signeture State 16 Sporks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Lest) 2. Dete of Deeth Month Helen Elizabeth Fowler NOVEMBER 30 1999 1:45 PM 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) 1□M 2DXF Months Days Hours 577-26-3418 87 Yrs. September 7, 1912 Washington, DC Usuel Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland St. Mary's Leonardtown 10e. Street end Number 10f. Zin Code 10g. Citizen of Whet Country? 41693 Park Avenue 20650 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Meritel Stetus 1 Naver Merried 2 Married 1 ☐ Yes 2X No Specify: Specify: 3 X Widowed 4 □ Divorced White 16a. Dacedant's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondary (0-12) Cotlege (1-4or 5+) l Year ER Nurse Hospital 17. Fether's Neme (First, Middle, Last) 18. Mothar's Nema (First, Middle, Maidan Sumama) William M. Hayden Sarah E. Payne 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Mary F. Russell / Daughter P.O. Box 2, Valley Lee, Maryland 20692 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Centery Cath. Centery 12/3/99 Valley Lee, Maryland 21. Signety of Funeral Service Licensee 22. Neme end Address of Fecility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonard town, Maryland 20650 Do not enter the mode of dying, such as cardiac or respiratory errest, Approx eves Pert1. Enter the disease, or complications that caused the days shock, or haart fellure. List only one cause on each line. Approximete interval Between Onset and Des Immediete Ceusa (Final disease or condition resulting in death) Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting In daath) Lest Due to (or as a consequence of):

Physician /Medical Examiner

Physician

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10a. State

Funeral

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28a-f show

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r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at

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Peges 1 and 2 should be filed within 72 hours effer death nent of Health end Mentel Hygiene.

At: If Item 27 is marked other than "natural", or items 23

of Hygiene.

permit. Pages 1 and 2:
Department of Health as
Important: If Itam 27 is
any injury or other trace

traumatic

Baltimore, Maryland 21215-0020

The law requires that the death certificete be executed physician the ed by the e ate hes been signed by page 2 should be detect After this certificate Physician: Attending

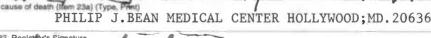
HELEN ELIZABETH FOWLER
Division of Vital Records, P.O. Box 68760,

Examiner Physician/Medicai ò Completed Be 2 filled in by the funeral Certification:

Pert II. Other signi	ficant conditions co	ntributing to death but not res	sulting in the underlyin	g cause given in Pert I.	23b. DI	d tobacco use c	ontribute to the caues of death		
					10	Yss 24No	3 Probably 4 Unknow		
					per	is en eutopsy formed?	24b. Wera autopsy findings evalleble prior to complation of cause of death?		
25. Wes case refar	rred to medicat			26. Ptace of	Deeth (Check only	ona)			
1 ☐ Yes 2	·No	Hospitat: 1 ☐ Inpatient 2	ER/Outpetient 3	g Homa 5 □ Ra	ma 5 ☐ Rasidence 6 ☐ Other (Specify)				
27. Menner of Deer 1 Netural 2 Accidant	5 Pending Invastigation		28b. Time of Injury M	28c. Injury et Work?		28d. Dascribe how injury occurred			
3 ☐ Suicide 4 ☐ Homicida	6 Could not be detarmined	28e. Plece of Injury - At h building, atc. (Special	ome, ferm, street, fac (y)	tory, office		(Street end Num own, Stata)	ber or Rural Route Number,		
29e. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	relcian: To the best of my kno lner: On the basis of axamine and menner steted.	wledge, deeth occurr tion end/or Invastigat	ed et the time, dete end plion, in my opinton, daeth o	ece, end due to th courred et the time	e ceuse(s) end n e, dete end place	nannar as stated. , and due to the cause(s)		
29b. Signeture end	title of certifier	\cap	^	29c. License number		29d. Dete sign	ed (Month, Dey, Year)		

State Registrar

JAMES P. JARBOE M. D 31. Dete filed (Month, Pay, Yeer) 32. Registrar's Signeture

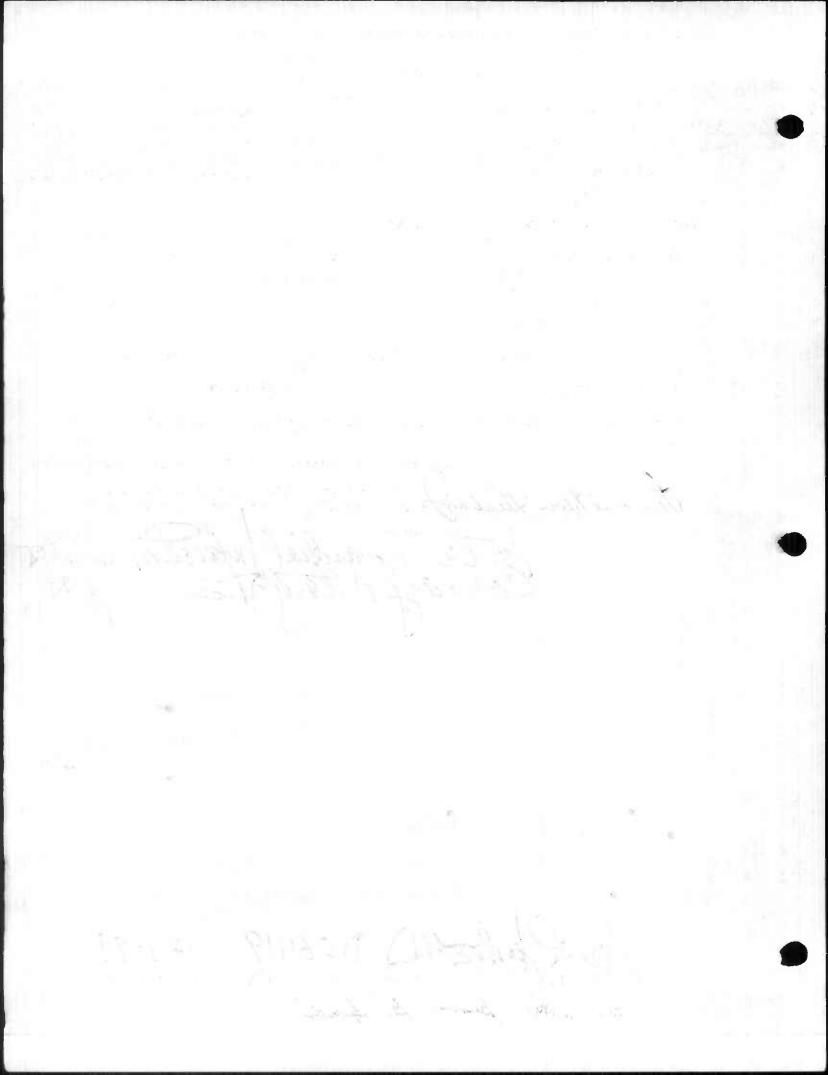


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30. Name end ed



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ogen C	. 2 - ~	17 12/23/99	State of N	/laryland /		artment of h <i>tificate of</i>	lealth and I <i>Death</i>		jiene leg. No.	9 4	1663	
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Less BURNICE LO: 4e. Facility Name (If not Institution, give HOMEWOOD RETIREME)	UISE FEI(street and numbe				4b. City, Town, or I		Dey 16 1 4c. County	Yeer 999 of Death	3. Tima of Death 11;30 PM	
Funeral Director		5. Social Security Number 6. Se 10 206 05 1400		Age (In yrs. last b	virthdey) Yrs.	If Under 1 Yaar Months Days	If Undar 24 Hrs. Hours Min.		Year)	9. Birthplac Country FINDL	ON ca (State or Foreign) LEY, OHIO	
Maryland	tor	Usuel Residence of Decedent 10a. Stete 10b. County MARYLAND WASHING	GTON	10c. City, Tov		cation				10d.	. Inside City Limits N☐ Yes 2☐ No	
h with the 23a or 28	ai Director	10e. Street and Number 16505 VIRGINIA AV	ENUE			10f. Zip Code 2]	1795	10g. Citizen of What Country? USA				
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28=4 show raumatic event, the Medical Eventines must be notified at	by Funeral	11. Marital Status 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forcas 1 Yes 2 If Yes, Give Year or Detes	No.	18	Vas Decedent of H Yas, specify Cub	Hispenic Origin? (S an, Maxican, Puert Specify:	pecify Yas or No- o Rican, etc.)		e - American ck, Whita, etc		
within 72 ho ena. then *netur	Completed	15. Decedent's Edi (Specify only highest grad	cation a completed) College (1-4o	r 5+)	(Give	ient's Usual Occup kind of work dona DO NOT use retire	during most of wor d)	18b. Kind of Businass/Industry MEDICAL				
id be filed ental Hygi ked other ic event, r	To Be Co	12 17. Fathar's Nema (First, Middle, Last) ROSS LATSHAW			KECI	IF I TON IS		ne (First, Middle, BESS R	Meiden Sumem			
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiena. Important: If tem 27 Is marked other than "natural", any injury or other traumatic event, the Medical Exa- once.		19e. Informent's Name/Reletionship (7) R. BRENT FEIGHT, (1			end Number or Ru				· .	
		20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ 6 4 ☐ Donetlon 5 ☐ Other (Specify)		20b. Plece cemete	of Dispo ery, cren	sition (Name of netory or other pla		C 20 199	20c. Location -	City or Town		
		21. Signature of Funeral Service Licens	all Vi	(1	D/	. Name and Addre	E F. S.	INC PO B	OX 179,	EVERF	TT 37 PA	
Physician /Medical Examiner	er	### Part f. Enter the disease, or comp shock, or heart feilure. List only of the limed lete Ceuse (Finel disease or condition resulting in deeth)	icetions their causine cause on aech	line.	ai	whi		or respiratory en	est,	ini	poroximata iterval Between inset and Deeth	
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law requires that the death certifics as been signed by the attending of \$2 should be delached for use as 1	Physician/M	Part II. Other eignificant conditions con	Jntributing to death	but not resulting	In the ur	nderlying cause giv	ven in Pert I.	23b. Did to	obacco uae cor	ntribute to th	ne cause of death?	
signed by to d be detact	by	Donoutia		NA	ile	scler	2565	1 🗆 Y	2 No	3 Probab	oly 4 ☐ Unknown	
a law requir has been s pe 2 should	Completed	Breest cance) <u> </u>					24e. Was e perfor	n autopsy med?	availa	autopsy findings able prior to eletion of causa ath?	
E 製品	Be Con	25. Was case referred to medical					26. Place of Dee	1 □ Y		1 🗆 Y	res 2□ No	
ing Phys Werthia uneral di	ဥ	examiner? 1 Yes 2 No 27. Menner of Deeth 1 Neturel 5 Pending 2 Accident Investigation	1 Inpat	jury 28b.	Time of Injury	28c. Inju		ome 5 Residence 128d. Dascribe h				
To the Hospital or Atland within 24 hours after death To the Funeral Director; / completely filled in by the I	Certification:	3 Sulcide 6 Could not be determined	28e. Pleca of lubuilding, o	njury - At home, f atc. (Specify)	erm, stre	eet, factory, office		28f. Location (S City or Tow	treet and Numb n, State)	er or Rural R	oute Number,	
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んなっ		29b. Signeture end title of cartil		\geq		29c. Licens	660	6	29d. Date signed	171	55	
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Gardia Bura

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Day Month Year **Eleanor** Irene Foley December 21, 1999 1:05 pm 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Allegany Memorial Hospital Cumberland If Under 1 Year If Under 24 Hrs 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours 1 □ M 2 TF Yrs. 212-24-1797 Sept. 16,1922 Maryland Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Hampshire 1 ☐ Yes &☐ No Green Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19 26722 P.O. Box US 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritel Stetus Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Home 12 Housewife 17 Fether's Name (First Middle Last) 18. Mother's Neme (First, Middle, Maiden Surname) John W. Lambert Nora B. Iser 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nora Glaze Daughter PO Boxz 19 Green Spring, WV 26722 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete Burial 2 Cremation 3 Removal from State Forest Glen Cemetery Dec. 23, 1999 Green Spring, WV 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Shaffer Funeral Home 21. Signeture of Funerel Service Licensee 114 230 E. Main St., Romney, WV 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Immediate Cause (Finel Chronic Obstructive Pulmonary Disease diseese or condition resulting in deeth) Years Due to (or as e consequence ot): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that Initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Nes 2 No 3 Probably 4 Unknown Hypertension, Cornary Artery Disease, 24b. Were eutopsy findings svailable prior to completion of cause of death? 24a. Wes en autopsy performed? Cerebrovascular Accident, Osteoarthritis, 1 Yes 2 1 No Hypercholesterolemia 1 ☐ Yes 2 1 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred

Physician **IMedical** Examiner

Department of Important: if any injury or

Physician

/Medical

Director

Funeral

ģ

Completed

Be

WV

Examiner

Funeral

Director

r 28a-f s

finer mast be n

than 'natural', or iter the Medical Examiner filed within 72 hours after

Hygiene.

Pages 1 and 2 should be fill ment of Health and Montal Hant. If Nam 27 is marked oth jury or other traumatic even

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records,

Examiner burial-transit The law requires that the death certificate be executed by Physician/Medical the 82 for use be detached Completed page 2 certificate or Attending Physician: funeral director, Be Certification: To After this To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

Medical w

Dr. Beverly Calkins, 31. Date filed (Month, Day, Year) DEC 28 1999 State Registrar

29b. Signature and title of certifier

1 Netural

2 Accident

3 Suicide

29e. Certifier

4 Homlcide

(Check only one)

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner es stated.
2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

December 21 D 54411 1999

Memorial Hospital Medical Bldg., Cumberland, MD 21502

1 ☐ Yes 2 ☐ No

5 Pending investigation

6 Could not be determined

32. Registrer's Signeture

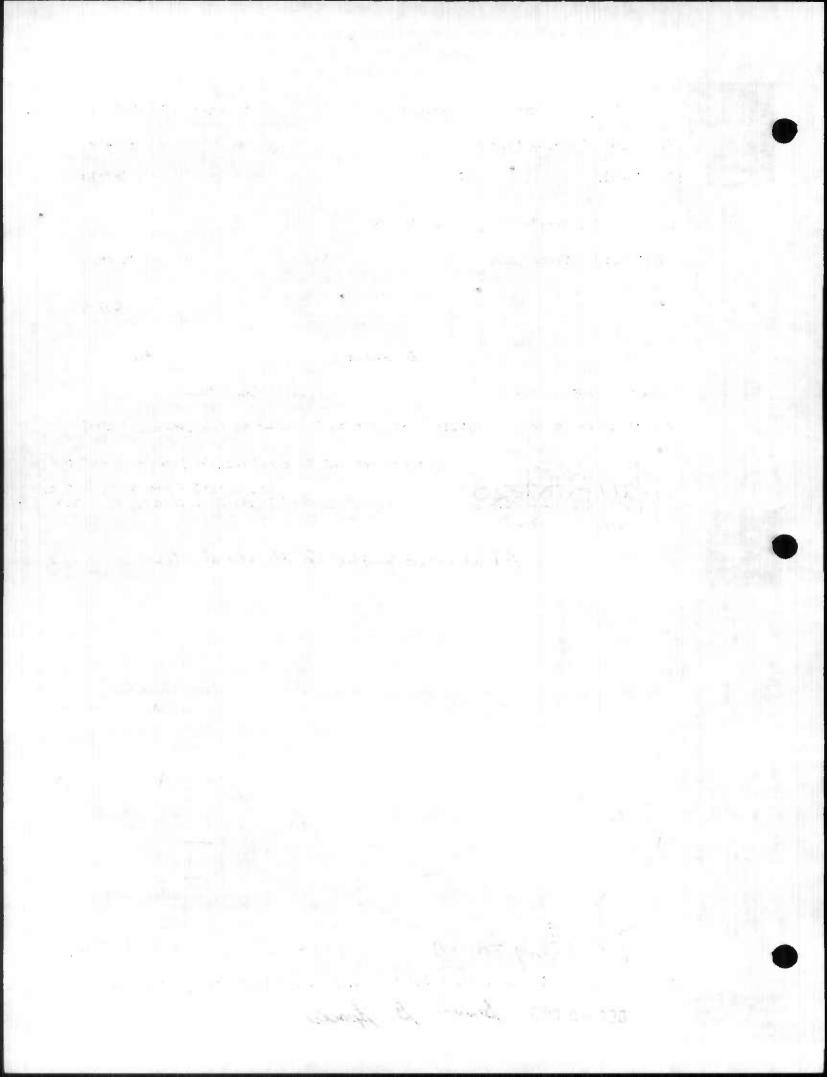
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

THE I R 1915 from 19 sporter

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					Cert	ificate of	Death		Reg. No.	9 41	665	
Physician /Medical		me (First, Middle, La Mary	Frances		aves			2. Dete of De Month Novembe	Dey 29, 1	999 7:	Time of Death	
Examiner Funeral Director	St. Man 5. Social Sacurity 577-45-4	y's Nursi Number 6.5	□ M 2 F		est birthday) Yrs.	If Under 1 Yea Months Days	4b. City, Town, or Leonardt If Under 24 Hrs Hours Min	OWN 8. Date of Bir	St.	Mary's	(State or Foreign	
and w	Usuel Residence 10e. Stete	10b. County		10c. City	, Town or Loca	ation				10d. I	nside City Limits	
with the Maryland a or 28a-f show Lbe notified at	MD	St. Mar	1	н	o11ywoo	od					Yes 2 No	
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23a or	25509 I	ocust Gre	en Lane			200	636		United	States		
urs after dea al', or frams Examiner m by Funer	11. Maritel Stetus		12. Was Decedant Armed Forces 1 Yes 2 If Yes, Give Year or Datas:	?			Hispenic Origin? (S ban, Mexican, Puar			Raca - Amarican Indian, Bieck, White, etc.		
within than than the Men	(Specification)	15. Decedent's Eacify only highest graceondary (0-12)	ducetion ade completed) Cottege (1-4or	5+)	16a. Decede (Give ki life. Do		pation e during most of wo ed)	16b. Kind of Business/Industry N/A				
tal Hyginal Hyginal district d	17. Fether's Neme	e (First, Middle, Last,)		11011101		18. Mother's Ne	me (First, Middle				
	Clarer	ce Thomas	Alvey				Cora He	lene Hay	den			
2 4 4 4	19a. Informent's I	Neme/Reletionship (Type, Print)		19b. Meiling	Address (Street	et and Number or R	ural Route Numb	er, City or Town,	State, Zip Coo	fe)	
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tmen tant: jury		5 ☐ Other (Specif		Ch			l Gardens	12/02/99	Leonar	dtown,	MD	
permit. Pages Department of I Important: If he any Injury or or once.	Mary	22. Name end Addrass of Facility Brinsfield Funeral Home, P.A. Mary B. Rizz 23a. Pentl. Enter the disease, or complications that deused the death. Do not anter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between										
/Medical Examiner bhysician and sthe burlat-transit and called Examiner adical Examiner	Immediate Cause disease or condit resulting in deeth self-transfer deeth self-transfer deeth self-transfer disease. Enter Unc Cause (Disease of their Initiated even resulting in deeth	conditions, immediate derlying or injury	b	Due to (or	es e conseque es e conseque as e conseque	ence of):	Cardy	veseda	direc	~	IAS,	
FD 45			d	_								
death certife attanding of for use a	Port II Other elem	ificant conditions	antribution to don'th	hut not requi	lting to the use	Indivine seven e	ives in Part I	22h Did	3b. Did tobecco use contribute to the cause of death?			
requires that the death certi een signed by the attending hould be deteched for use a hould by Physician/M	Pert II. Other sign	incent conditions o	ontributing to deeth	out not resu	ming in the und	enying ceuse g	Iven in Pert I.		Yes 2 No		y 4 Unknow	
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The la								1 🗆	Yes 2 No	1 □ Ye	s 2 No	
certificata rector, pag	25. Wes cese refe axeminar?	erred to medical						eth (Check only	one)			
T digital	1 Yes 2	No	Hospital: 1 ☐ Inpat		ER/Outpatient	3LI DOA		Home 5 Resi				
fter ine	27. Manner of Dea	5 Pending	28e. Date of Inj (Month, De	ury ey Yeer)	28b. Time of injury		ury et ork?	28d. Describe	how injury occur	rred		
= . 2 2								28f. Location (Street end Number or Rural Routa Number, City or Town, State)				
or Attendir after death. Diractor: Af in by the fu	4 🗌 Homicide		29a. Certifier (Check only 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner as stated.									
e Hospital or Attending P 24 hours after death. • Funerel Director: After t lataly filled in by the funer dical Certification:		Certifying Ph		of examinet								
o the Hospital or Attendir ithin 24 hours after death. o the Funerel Director: Af omplataly filled in by the fu Medical Certification	29a. Certifier (Check only	Certifying Ph	niner: On the besis of	of examinet		stigetion, in my				end due to the	ceuse(s)	
he Hospi in 24 hound he Funer plataly fil edical	29a. Certifier (Check only one)	Certifying Ph	niner: On the besis of	of examinet		29c. Licar	opinion, deeth occ		date end place, 29d. Data signe	end due to the	ceuse(s)	
To the Hospital or Attendity within 24 hours after death. To the Funeral Director: A, comparally filled in by the funeral Medical Certificatificatificatificatificatificatificatificatificatificatificatificatificatificati	29a. Certifier (Check only one) 29b. Signature and	Certifying Ph	niner: On the besis of	of examinetil teted.	on end/or Inve	29c. Licar	opinion, deeth occurs number	urred et the time,	29d. Data signe	end due to the	ceuse(s)	

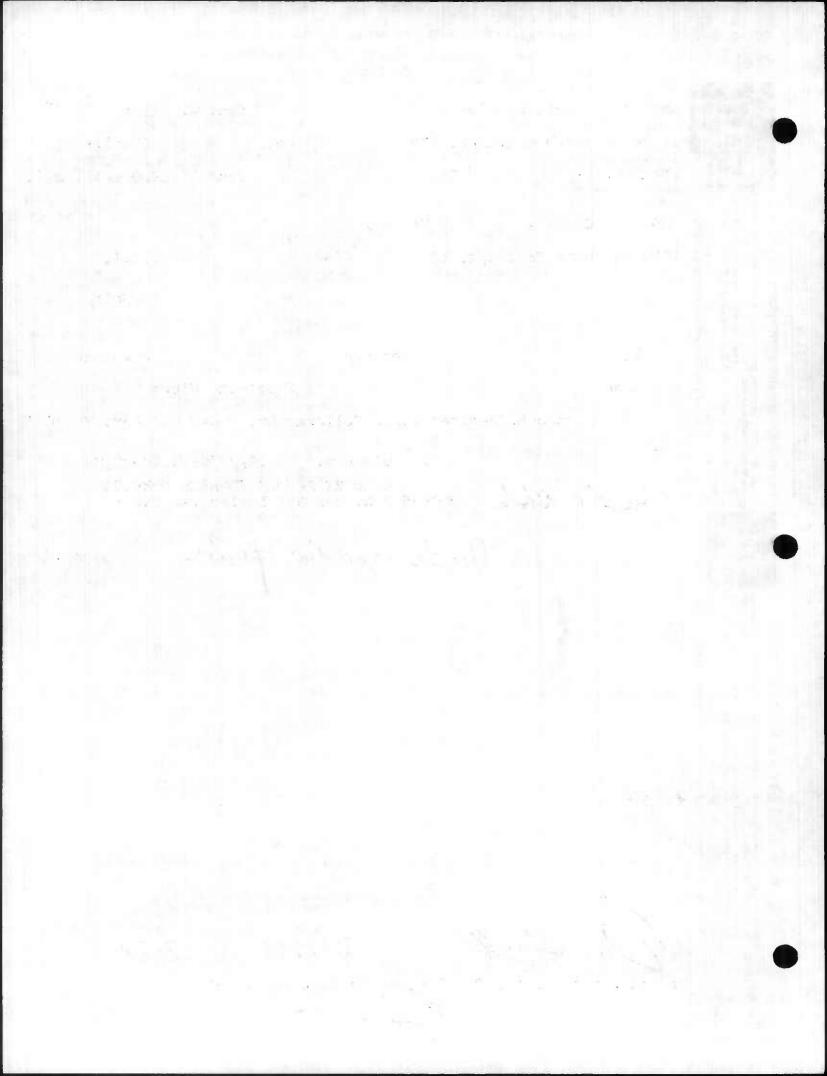
DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 4 6 6 6 Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) **Physician** 8:14AM Dorothy Charlotte 21 1999 Dec. /Medical 4b. City, Town, or Location of Death 4e Facility Nema (ff not institution, giva street end number) 4c. County of Death Examiner 11080 Waymouth Crt. Apt. 129 Waldorf Charles If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Dev. Year) Birthplece (State or Foreign Country) **Funeral** Deys Hours Min 1□ M 2□ F 579-34-0414 Yrs. 69 **Director** June 19 1930 Wash. D.C. Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show yinjury or other treumatic event, the Medical Exertines trust be notified at once. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11080 Waymouth Crt. Apt. 129 20603 U.S.A. Funeral 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1 Yes 2000 off Yes, Give Yeer or Detes: 1 Never Married 2K Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Hostess Restaurant 18 Mother's Neme (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) Lee Rank Charlotte Hicks 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Reletionship (Type, Print) Beverly Cavanaugh/Daughter 10812 Hollaway Dr. Upper Marlboro, MD 20772 20b. Place of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Suriei 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Pauls Cem. 12/27/99 Waldorf, MD 21. Signeture of Funerel Servica Licanses ÄREHART-ECHOLS FUNERAL HOME, PA MO0945 P.O. Box 567 LaPlata, MD 20646 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Ceuse (Final disaase or condition resulting in deeth) Examiner Examiner physician and the burial-transit The law requires that the deeth certificate be executed Sequantially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical Due to (or as a consequence of) 987 signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No à 24b. Were autopsy findings evailable prior to complation of cause of death? should Completed 24a. Wes en eutopsy irector, page 2 s 1 ☐ Yes 2X No 1 Yas 2 No al or Attending Physician: T s after death. i Director: After this certificet of in by the funeral director, p 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28d. Dascribe how Injury occurred 28a. Dete of Injury (Month, Dey Year) 28h Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 Tyes 2 No investigation 2 Accident the Funeral Directory filled in by the 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner as stated. Medical To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examinetion end/or Investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) and eddress of person who completed cause of deeth (Item 23e) (Type, Print) Daniel Howell, MD 605 Charles St. La Plata, MD 20646 31. Dete filed (Month, Dey, Year) 32. Registrer's Signat

DHMH 16 Rev 6/95

State Registrar



Physician

/Medical

Examiner

Funeral Director	5. Social Security Number 212-38-5590	6. Sex 7 1 M 2 √ F	7. Age (In yrs. last b	Yrs. If Under 1	Year If Under 2 Days Hours	Min. (Month,	Day, Year)	Birthplaca (State or Foraign Country)
	Usual Rasidance of Decedent					DEC 2	25 1909	MARYLAND
Pu Res	10a. Stata 10b. County		10c. City, Tov	n or Location				10d. Inside City Limits
the Marylan 28a-f show notified at	MARYLAND ALLI	EGANY	cur	MBERLAND		15 TO 15		1 Yes 2□ No
5 0 8 0		STREET		10f. Zip 0	21502		10g. Citizen of U.S.A	What Country?
5 2 2 5	3 Widowed 4 □ Divorced	Armed For	1	13. Wes Decede If Yes, specif		can, Puerto Rican, atc.)		ce - American Indian, ick, Whita, atc. fy: WHITE
ind 21215-00 be filed within 72 hour lei Hygiene. dother the natural south, the Medical La Went, the Medical La Be Completed b	15. Deceder (Specify only highe	t's Education st grade completed)		Decedent's Usual (Give kind of work lifa. DO NOT use	Occupation done during most retired)	of working	16b. Kind of E	Business/Industry
and 2121 be filed within tiel Hygiene. d other than event, the Me	Elemantary/Secondery (0-12) 12+	College (1-		HOOL TEAC	HER		TEAC	
Taryland 2 should be filed and Mentel Hygi le marked other sumatic event, To Be Co			r's Name <i>(First, Mide</i> E FOYE	dle, Maiden Sumai	ma)			
other tr	19a. Informant's Name/Relations LOUISE VANMETER 20a. Method of Disposition 1XABurial 2 Cramation 4 Donation 5 Other (S	3 □Removal from S	AUGHTER 20b. Place comate		456 RII	GELEY W.1 Data 27: 1999	7A. 2675 20c. Location	
Baltimo	21. Signatura of Funaral Service	Licensed	V	MERRITT		, JNERAL HON EET CUMBER		IVI AND
Physician /Medical	23a. Part1. Enter the disease, or shock, or heart lailure. List Immediata Causa (Final disease or condition	only one cause on aa	used the death. Do ch line.	not enter the mode	of dying, such as o	cerdiac or raspirator	y arrest,	Approximate Interval Between Onset and Death
P.O. Box 68760, tat the death certificate be swecuted by the ettending physician and letached for use as the burist-transit physician/Medical Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	Due to (or as a	consequence of): consequence of):				
al Records, P The lew requires that cate has been signed be page 2 should be deter						pe	las an autopsy erformed?	24b. Ware autopsy tindings available prior to completion of causa of death?
Ficat Ficat C	25. Was casa refarred to medica				50 Di			10,100 20,100
Vital victor: 1 certifica irector, p	axaminar?	Hoenital:			Other	of Death (Check on		h
Division of Vital Recontration: The lew of Attending Physicien: The lew of Attending Physicien: The lew of Attending Physicien: The lew of Attending Physician Property of Attending Physician Operation of Attending Physician Operati		28a. Data of (Month	Injury , Day Year)		Unjury at Work?		esidence 6 LIOT be how injury occu	
Division of attending P after the or attending P or after deeth. The Director: After the or in by the funer or in by the funer Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	of Injury - At homa, f g, etc. <i>(Specify)</i>	arm, street, factory,	office		n (Street and Num Town, Stata)	ber or Rural Route Number,
Divi	29a. Certifier (Check only one) Certifyir 2 Medical	g Physician: To the b Examiner: On the bas and manne	is of axamination at	e, death occurred et ad/or investigation, i	the time, data and my opinion, deet	d place, and due to the time	ha cause(s) and m ne, data end place	nannar as stated. , and due to the cause(s)
m m	29b. Signatura and titla of continu	who			License number		-	ed (Month, Day, Year) OCR 22, 1999
,10	30. Name and address of person DR VIK POONAL	920 NAT	CIONAL HIC		VALE, MA	RYLAND 2	1502	
State Registrar	31. Data liled (Month, Day, Year) DEC 2 3	1999 32. Re	gistrar's Signatura	& So				

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State of Maryland /

	2. Date of Death		3. Ti	me of	Dea	lh
Certificate of Death	Reg. No.	99	41	6	6	8
Department of Health and	Mental Hygiene	00				

Physician /Medical **Examiner**

Patrick Havden 4a Fscility Name (If not institution, give street end number) PRINCE GEORGES HOSPITAL CENTER

Month DEC. 2, 4b. City, Town, or Location of Death

3. Time of Death 1999 0505 AM

Funeral

5. Sociel Security Number 7. Age (In yrs. last birthday) 1 M 2 F 217-11-6928 21

CHEVERLY If Under 1 Year Months Days

PRINCE GEORGES

4c. County of Death

Director

mant be notified at

Пета

5

"natural",

I Hygiene.

Pages 1 and 2 should be in nent of Heelth and Mental I ant: If Item 27 is marked or

other

6 Department of Important: If any Injury or Directo

Funeral

à

Completed

Be

death with the Meryland

filed within 72 hours after

21215-0020

Baltimore, Maryland

10a. Stete 10b. County

1. Decedent's Neme (First, Middle, Last)

10c. City. Town or Location

Hunder 24 Hrs. 8. Date of Birth (Month, Day, Year) November 1978

18. Mother's Name (First, Middle, Maiden Surname)

9. Birthplace (State or Foreign Country)
Mary Land

Usual Residence of Decedent

Maryland

Shawn

St. Mary's Hollywood

10d. Inside City Limits 1 ☐ Yes 2 ☐ No

10e. Street and Number

11. Merital Stetus

25722 Ricky Drive

1 ☑ Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:

20636 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

USA 14. Race - American Indian. Black, White, etc.

10g. Citizen of What Country?

1 ☐ Yes 2 ☐ No Specify:

10f. Zip Code

Specify: White

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working tile. DO NOT use retired)

16b. Kind of Business/Industry Masonary

12th Grade 17. Father's Name (First, Middle, Last)

Joseph

Aloysius

Hayden, Jr.

Margaret

Ellen

Moore

19a. Informent's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

25722 Ricky Drive, Hollywood, Maryland 20636

Margaret H. Stone (Mother)

20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Charles Memorial Gardens

Laborer

Date 20c. Location - City or Town, State

12/6/1999 Leonardtown, Maryland

21. Signature of Funeral Service Licenti

ichael of

22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

23a. Pert . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line.

Onset end Deeth

Physician /Medical Examiner

and

use as the

signed by the at d be detached for

has page 2

certificate

this

After

To the Hospital or Attai within 24 hours after dea To the Funeral Director completely filled in by the

10

funeral director.

or Attending Physician:

The law requires that the deeth certificate be executed

Box 68760.

Division of Vital Records, P.O.

Physician/Medical Examiner

Completed by

Be

Medical Certification: To

Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

Immediate Cause (Finel disease or condition resulting in death)

Due to (or es e consequence of):

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No

3 Probably 4 Unknown

24a. Was en eutopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one)

Yes

25. Was case referred to medical XIX Yes 2 No 27. Menner of Deeth

Hospital: 1 ☐ Inpatient 2XXER/Outpatient 3☐ DOA 28e. Date of Injury (Month, Day Year)

28b. Time of Injun Placa of Injury - At hom building, etc. (Specify) 0130

28c. Injury et Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

include 1000 28f. Location (Street and Number or Rural Route Number City or Town, Stafe)

29a. Certifier (Chec dk only

1 Naturel

28 Accident

3 Suicide

4 Homicide

Sife KTE 235 01 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

At home, farm, street, factory, office

29b. Signature and title of certifie

5 Pending investigation

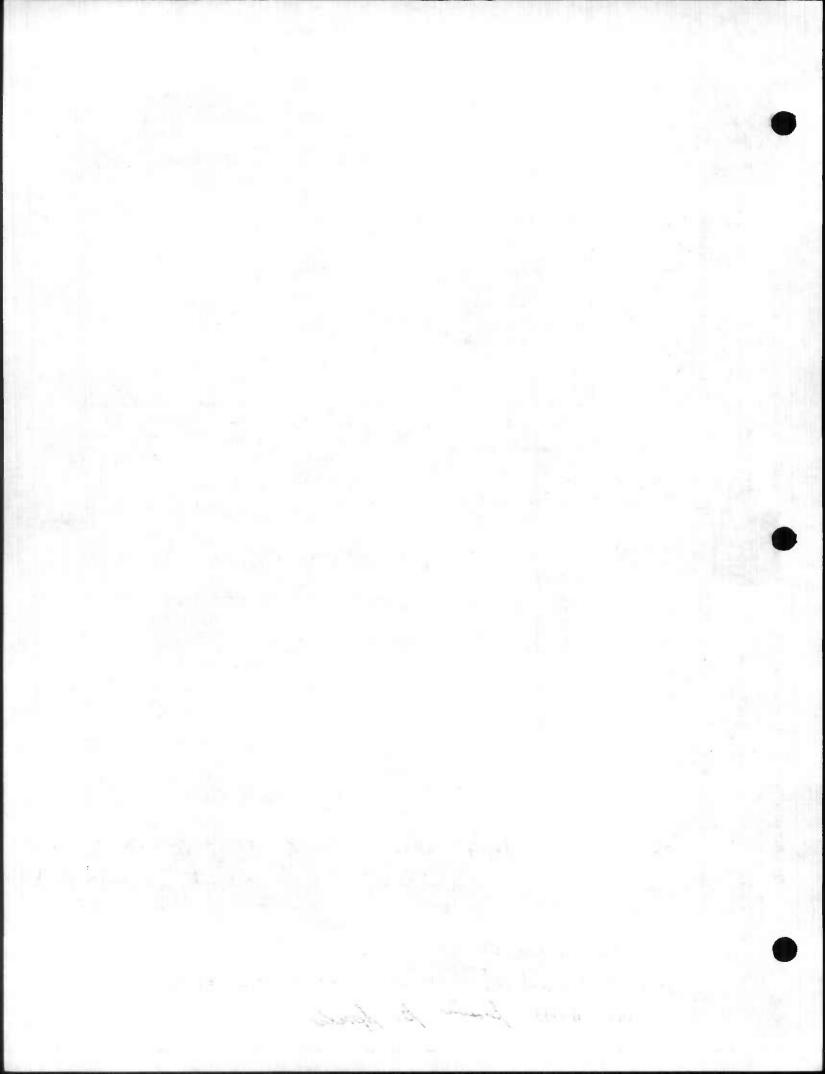
6 Could not be determined

29c. License number O.C.M.E 29d. Date signed (Month, Dey, Year) DEC. 2, 1999

e end address of person who completed cause of death (Item 23a) (Type, Print) My Aron KE

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Dete filed (Month, Dey, Year) DEC - 6 1999 32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene o Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Mary Theresa Holt December 24,1999 9:30 A.M. 4a Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 28845 Pt. Lookout Road Morganza If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) Deys 1□M 2/2 F Months 60 218-38-8405 November 20, 1939 Maryland Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Maryland St. Mary's Morganza 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28845 Point Lookout Road 20660 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Merital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 ☐ Divorced Yeer or Detes 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Nelson Mary Short 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Philip I. Holt/ Son 28845 Point Lookout Road, Morganza, Maryland 20660 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1X Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) Outen of Peace 12/30/99 Helen, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility Dunn & Sons Funeral Service 5635 Eads Street N.E. Washington, DC 20019 23a. Part1. Enter the disease, or compileations that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth · Metastatic Rectal Adeno Carcinoma Immediata Causa (Final diseese or condition resulting in deeth) Due to (or as e consequence of) Dua to (or es a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Staphyl coccol Uro sepsis 1 No 3 Probably 4 Unknown 24a. Was an autopsy

Physician /Medical Examine

physician and the burial-transit

been signed t should be det

funeral director.

this

After

n 24 hours after death e Funeral Director: A pletely filled in by the f

To the Hosp within 24 ho To the Fune completely fi

death.

ò Hospital 8

Certification: To

Medical

that the death certificate be executed

P.O. Box 68760.

Records,

Division of Vital Attending Physician:

The law requires

important: If item 27 any injury or other to

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show notified at

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Pages 1 and 2 should be nent of Health and Mental

Directo

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Completed

Be

the Maryland

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Examiner Sequentially list conditions, if eny, leeding to immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Physician/Medical þ Completed

4 Homicide

Renal Insufficiency

26. Place of Deeth (Check only one)

24b. Were autopsy findings aveilable prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Cerebro Vascular 25. Wes case refarred to medical examiner? Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No

Other: 4 Nursing Homa 5 N Residence 6 Other (Specify)

27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 5 Pending investigation Vaturel 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify)

28b. Time of 28c. Injury et Work? 1 Yes 2 No

28d. Describe how injury occurred

29a. Cartifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and meaner stated.

29b. Signature end title of certifie anine 29c. License number 00052

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

James Harring 22576 McArthur Blvd. California, MD 20619 31. Data filed (Month, Dey, Year)

State Registrar

DEC 2 9 1999

32. Registrer's Signeture

DHMH 16 Rev 6/95

from to speece

848 9 3 03b

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 4 1670

			Certific	ate of Death	Re	g. No.	i de la			
Physician /Medical	Decedent's Name (First, Middle, La Walter Vincent				2. Data of Deat Month December	Day		7 ime of Death 00 p.m.		
Examiner	4e Facility Nama (If not Institution, given 41515 Hayden Fam			4b. City, Town, o	r Location of Death	4c. County	of Death Mary's			
Funeral Director	217-36-7534	Sex 7. Age (In y. 70 age) 7. Age (In y. 70	Mont	der 1 Year If Under 24 Hr ns Days Hours Mir		^{Year)} 1923	9. Birthplaca Country) Maryla	State or Foreig		
r 28a-f show routed at	10a. State 10b. County Maryland St. Mai	_	City, Town or Location Leonardtow	n			100	sida City Limite		
ritems 23s or 28s-fsi whet must be notified Funeral Director	10e. Street end Number 41515 Hayden Fam	n Lane	10f.	Zip Code 20650						
by by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Evar in Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Yaar or Dates:	If Yas, s	cedant of Hispanic Origin? (pecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, atc.)	o- 14. Race - American Indian, Black, White, etc. Specify: White				
lygiene. ner than "natural", n', i're Medical Exe Completed by	15. Decedent's E (Specify only highest gra	ducetion ade com <i>pleted)</i>	16a. Decedent's U	sual Occupation work done during most of w Tuse retired)	orking	16b. Kind of Bi	usiness/Industry			
ther than	Elementery/Secondary (0-12)	College (1-4or 5+)	Farme			Agricu	lture			
Be ve	17. Father's Name (First, Middle, Last Joseph Ignatius I	,			ama (First, Middle, A Sheehan	<i>Maiden Sum</i> am	(8)			
T le m traum	19a. Informant's Name/Relationship (Janice W. Hayden)			ess (Street and Number or I						
nt: If item 27 I	20a. Method of Disposition 1 ■ Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State	. Place of Disposition (cametery, crematory	Vame of		20c. Location -	City or Town, S	State		
Department Important: If sny Injury o phoe.	21. Signature of Funeral Service Lice	0 1 1	22. Name 0052 22955	and Address of Facility Bi	rinsfield	Funera dtown,	1 Home,	P.A. 0-0279		
	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ceused the de one cause on each line.					App	roximate val Between et and Death		
edical eminer	Immediate Cause (Final disease or condition resulting in deeth)	a. Aint	e Leukem o (or as a consequence	of):			2	yeurs		
s the buriel-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying	b. Due to	(or as e consequence	of):				- 1		
a a a	Cause (Disease or Injury that initiated events rasulting in death) Last	Due to	(or as a consequence	of):						
a attend ad for us sician/	Part II. Other significant conditions of	contributing to death but not r	esulting in the underlyin	g cause given in Pert I.	e given in Pert I. 23b. Did tobacco use contribute to the cause of death					
gned by the attenct be dateched for us by Physician	() :	Print's						4 Unknow		
2 should	anemic an				24e. Was e perform	n autopsy ned?	avallabl	utopsy findings e prior to ion ot ceuse ?		
cartificate harector, page					1 □ Ye	s 2 No	1 Tes	2□ No		
al director,	25. Was cese referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐	Other:	eath (Check only on Home 5 Reside		er (Specify)			
Aftar th funeral	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year,	28b. Tima of	28c. Injury at Work?	28d. Describe ho					
Mining a nous and death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 Suicida 6 Could not be determined		t home, farm, street, fac cify)	tory, office	28f. Location (St City or Town		per or Rural Rou	ite Number,		
To the Functal Direct completely filled in by Medical Certifi	29a. Certifier 1 Certifying Pt (Check only one)	nysician: To the best of my k niner: On the basis of exemi and manner stated.	nowledge, deeth occurring	ed at the time, data and pla- ion, in my opinion, deeth oc	ce, and due to the co curred et the time, do	ause(s) and ma ete end plece,	anner es stated and due to the	ceuse(s)		
To the	29b. Signature and title of certifier	lh		29c. License number D39979			21, 19			
State	30. Name and address of person who William K. Kelly, 31. Data filed (Month, Day, Year)	M.D., 25500	Point Look	out Road, Leo	nardtown,	Maryla	nd 2069	50		

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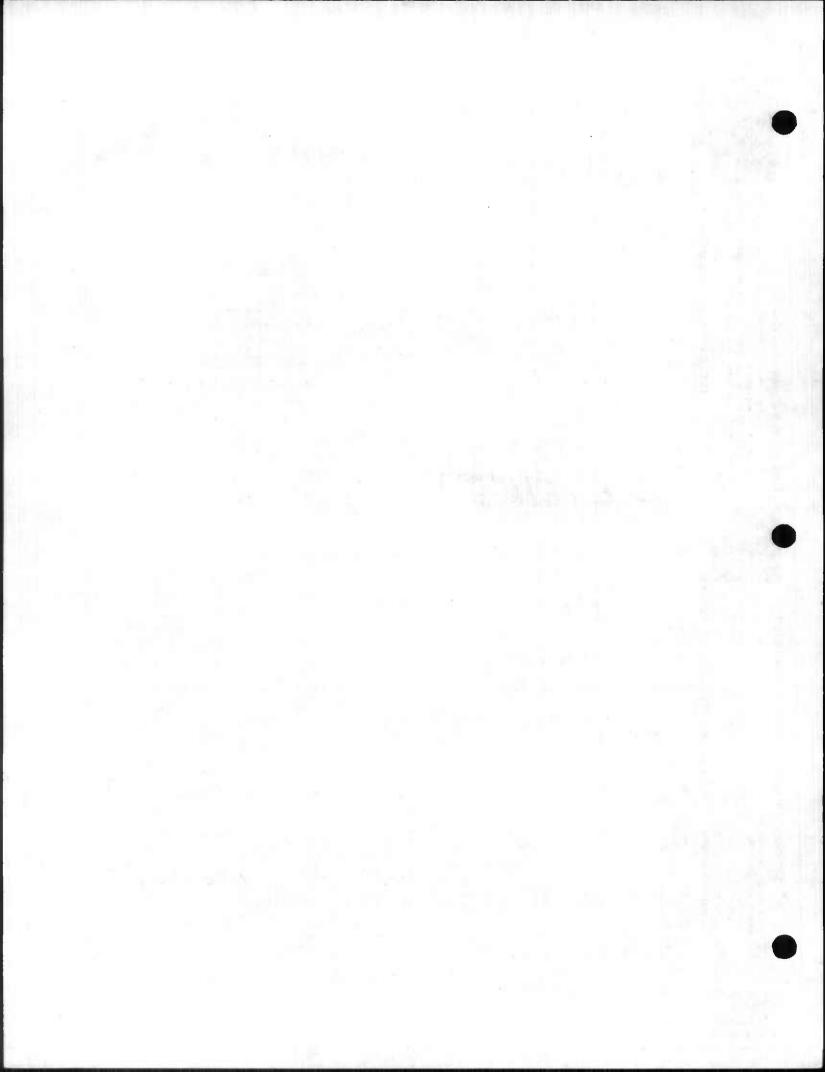
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THOMAS HOUCTLE

State of Maryland / Department of Health and Mental Hygiene

CLAUDE THO	DMAS HOUCILE Certificate of Death	•	Reg. No. 99	41671					
Physician	Decedent's Name (First, Middle, Last)	2. Date of De Month		3. Time of Death					
Physician /Medical	CLAUDE THOMAS HOUCK	DEC.	22, 1999	6:57 AM					
Examiner	4a Facility Name (If not institution, give street end number) 4b. City, Town, or L 6250 RIPLEY ROAD LA PLATA		4c. County o						
Funeral Director		(Month, De	y, Year) 9,1918 1	9. Birthplace (State or Foreign Country) North Caroli					
tand tand	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits					
a-f ah ura-d	MD Charles La Plata			1 ☐ Yes 2 No					
or 28	10e. Street and Number 10f. Zip Code		10g. Citizen of Wh	nat Country?					
ath w	6250 Ripley Road 20646		USA	A market bades					
UZU uns after death with the Mai el; or iteme 23a or 23s-f a el: or iteme 23a or 25s-f a by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Amped Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amped Forces? 1 Never Married 2 Married 3 No WWII they see Year or Detes: 13. Was Decedent of Hispanic Origin? (Specify Cuban, Mexican, Puerto they see Year or Detes:	Rican, etc.)	Specify:	- American Indian, White, etc. White					
Indeed to the control of the control	15. Decedent's Education (Specify only highest grade completed) [Give kind of work done during most of work life. DO NOT use retired)	king	16b. Kind of Bus	iness/Industry					
	Elementery/Secondery (0-12) College (1-4or 5+) Carpenter 2	Construction							
	17. Father's Name (First, Middle, Last) 18. Mother's Nem								
	Austin Houck Roseman 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rur	-							
	Thelma Houck/Wife 6250 Ripley Rd. La								
Saltimore, permit. Peges 1 en Department of Heeli Important: if item 2 any injury or other sales.	20a. Method of Disposition 1 XBuriat 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Neme of cametery, cremetory or other place) Trinity Memorial Gar.1	Dete 2/28/9		orf, MD					
pemit. Peg Department Important: It any Injury o	21. Signature of Funeral Service Licensee WCOS/7 AREHART – ECHOLS F P.O. BOX 567 LA	FUNERAL	HOME,	P.A.					
	23a. Part 1. Enter tide disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Intervel Between					
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting In death) e. Multiple Injuries Due to for as a consequence of):			Onset end Death					
od sir	b.————————————————————————————————————								
g physician and as the buriel-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of):								
2 0 0	that initiated events resulting in death) Last Due to (or es a consequence of):								
the death certy the attending to the for use in hysician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	tobacco use cont	e contribute to the cause of death?						
T ta de d	tartin significant conditions contributing to country at the tributing in the disconjung datase growth in Yart.		23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown						
The law requires that he has been signed by page 2 should be determined by PI			en autopsy med?	24b. Were eutopsy findings available prior to completion of cause of death?					
The page		12	Kes 2□No	No 2□ No					
Certificat rector, pa	25. Was case referred to medical examiner? Hospitet Other: Other:								
To the Hospital or Attending Physician: within 24 hours after death to the Funeral Director. After this certific completely filled in by the funeral director, Medical Certification: To Be (XX Yes 2 No	28d. Describe	dence 650ther now injury occurre ign 5 truck						
To the Hospital or Attending Physician of Within 24 hours after deeth. Completely filled in by the funeral Completely filled in by the funeral Medical Certification: 7	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 5 + C +	28f. Location (S City or Ton La Plat	Street end Number vn, State) 6250	or Rural Route Number,					
n 24 hound no 24 h	29a. Certifier (Check only one) 1□ Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, the time of the time of the time, dete end plece, the time of the time of the time, dete end plece, the time of the time of the time, dete end plece, the time of the time of the time, dete end plece, the time of time of time of the time of t								
Vithin Somple	29b. Signature and title of certifier 29c. License number		29d Date signed	(Month, Dey, Year)					
F 5 F 0	O.C.M.E		DEC.	23, 1999					
	30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Dev 201 The first street, Baltimore	e, Mary	land 212	01					
State Registrar	31. Date filed (Month, Dey, Year) DEC 2 7 1999 32. Registrar's Signature 4. Aparll								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death Month Dev Yee CHARLES BEVERLY HOLTZMAN 21, 1999 4c. County of Deeth December 5:15 am 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Desth Cumberland Memorial Hospital **Allegany** 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Ve Birthplace (State or Foreign Country) 6. Sex. Months Hours Davs 214-07-1076 MARYLAND Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d Inside City Limits ¥XYes 2 No MARYLAND ALLEGANY CUMBERLAND 10e Street and Number 10f. Zip Code t0g. Citizen of What Country? 413 ARCH STREET 21502 U.S.A. 12. Wes Decedent Ever in U.S. Armed Forces? ¥24Yes 2 □ No If Yes, Give Yeer or Dates: WW 1 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11 Marital Status 1 Never Merried Merried 1 Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) KELLY SPRINGFIELD TIRE CO. MANUF. TIRES 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) EDGAR C. HOLTZMAN CARRIE E. WILSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) MARCIA BARTLETT 25 MORAN AVE. DAUGHTER CUMBERLAND MARYLAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Dete 1 ⊠ Burial 2 □ Cremetion 3 □ Removel from Stete SUNSET CEMETERY DEC 22 1999 CUMBERLAND MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) e of Funeral Sen 22. Name and Address of Facility MERRITT-ADAMS FUNERAL HOLL 404 DECATUR STREET CUMBERLAND MARYLAND Approximate Interval Between Onset and Death MERRITT-ADAMS FUNERAL HOME P.A. erub d. 23a. Pert1. Enter the disease, or or shock, or heart feilure. List or uplications that caused the death. Do not enter Immediate Ceuse (Finel disease or condition resulting in deeth) SUPRANUCLEAR PALSY Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Lsst Due to (or es a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yea 20 No 3 Probably 4 Unknown 24b. Were eutopsy findings sveileble prior to 24e. Wes en eutopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Wes case reterred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA

Physician /Medical Examiner

Physician

/Medical

Director

Funeral

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Hygiene.

Pages 1 and 2 should be nent of Health and Mental

nt of Health a : If flam 27 is or other tra

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filed within 72 hours after

Baltimore, Maryland 21215-0020

Examiner The lew requires that the death certificate be executed eun signed by the attending to be detached for use has page 2 certificate funeral director, After this

214-07-1076

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Division of Vital Records,

Charles Holtzman

Physician/Medical Completed by 8

or Attending Physicien: Medical Certification: To death. To the Hospital or Attend within 24 hours after death To the Funeral Director. filled in by completely AL 3

1 ☐ Yes 27. Mannay of Deeth urel 2 Accident 3 ☐ Suicide 4 Homicide

> 29e. Certiflei (Check only one) 29b. Signeture end, thie of certified

5 Pending Investigation

6 Could not be determined

28a. Dete of Injury (Month, Day

un m

Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

D25406

29c. License number

28c. Injury at Work?

1 Tyes 2 □ No

Kertifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es steted. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and pisce, and due to the cause(s) and menner stated. 29d. Date signed (Month, Day, Year)

1999

December

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. William D. Lamm 47 Virginia Avenue Cumberland, MD

31. Dete tiled (Month, DEC State Registrar

2 2 1

32. Registrar's Signature

28b. Time of

DHMH 16 Rev 6/95

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TERRY	JE:	State of Maryland / Department of Health and I Certificate of Death	Mental Hyg	-00	41673
Physic /Med Exam	lical	1. Decedent's Name (First, Middle, Last) Terry Michael Jefferys 4a Facility Name (Il not institution, give street and number) IN FRONT OF 15113 MT. SAVAGE ROAD MT. SAV		Day Year	
• Funera Directo		5. Social Security Number 197 ~ 68 ~ 1658 6. Sex 1 M 2 F 27 7. Age (In yrs. last birthday) H Under 1 Yeer H Under 24 Hrs. Months Days Hours Min.		9 Birth	nplaca (State or Foreign unity) Maryland
or 28a-f show be notified at	tor	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location Penns ylvania Bedford Hyndman			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
th with the 23s or 28 ust be not	al Director	10e. Street and Number 101. Zip Code 163 Washington Street 15545	1	Og. Citizen of Whet Co United St	
-0020 hours after dea furel', or items at Examiner m	by Funeral	11. Merital Status 1 Merital	pecify Yes or No- o Rican, etc.)	14. Raca - Ame Black, White Specify: W	
Maryland 21215-0020 of 2 should be filled within 72 hours at the and Mental Physiene. T is meriked other than "natural", or traumatic event, the Medical Exam	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) College (1-4or 5+) College (1-4or 5+) Heavy Machine Operator	rking	16b. Kind of Business/I	
	To Be C	Stanley Michael Jefferys Rae Paul	ne (First, Middle, I Lette Bri	ck	
~ 등등등등		19a. Informant's Neme/Relationship (Type, Print) Stanely Michael Jefferys Father 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Departing 5 Other (Specify) 19b. Mailing Address (Street end Number of Ruman, Father PO Box 529 Hyndman, Father Possition (Name of Cemetery, cremetory or other place) Hyndman Cemetery December	Pennsylva Date	Lnia 15545 20c. Location - City or	
Baltimore permit. Pages 1 Department of Hi Important: if then any Injury or oth		21. Signature of Funeral Service Licensee 22. Name end Address of Facility Hahvau H 70 i of an	Funeral	Home	
Physician /Medica Examine	l r	23a. Pent 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of):	c or respiratory arr	ries.	Approximate interval Between Onset and Deeth
. Box 68760, death certificate be executed e attending physician and of for use as the burial-fransit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last b. Due to (or es e consequence of): c. Due to (or as a consequenca of):			
O the	Physician/M	Pert If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did to	./	to the cause of death?
ecords, aw requires se been sign 2 should be	Completed by		24e. Was a perfor	med?	Were autopsy findings evailable prior to completion of cause of death.
Vital clan: T clan: T serificate ector, pu	Be	examiner? Hospitel: Other:	oth (Check only or	ne)	1 d Yes 2 □ No
Division of or Attending Physiter death. Mrector: After this in by the funeral di	Certification: To	27. Menner of Deeth 1 Natural 2 Maccident 3 Suicide 4 Homicide 1 Natural 2 Number of Injury 1 Natural 2 Number of Injury 1 Natural 2 Number of Injury 3 DOA 4 Number of Number of Injury 4 Number of Injury 4 Number of Injury 5 Number of Injury 6 Number of Injury 6 Number of Injury 7 Number of Injury 8 Number of Injury 8 Number of Injury 9 Number of Injury 1 Number of Injury 9 Number of Injury 1 Number of Injur	28f. Location (S City or Town	ow injury occurred tree and Number or Riverses All e	otor vehicle rolled vehicle ural Ploute Number, 3 any County, Ny
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece (Check only one) Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end plece (Check only one) 29b. Signature and titlerol certifier 29c. License number	urred at the time, d	ate and plece, and due	h, Day, Year)
wolk	2 \ 2	O.C.M.E. 30. Name and address of person who completed cause of death (Ifem 23a) (Type, Print)		DECEMBER :	26, 1999
S Regis	tate trar	DEC 28 1999	nry⊥and 2	1201	

State Registrar DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O

Certificate of Death 1. Decedant's Nama (First, Middle 1 ast) 2. Data of Death **Physician** 720 pm Dewember 92, 1999 Lois Ruth Korns /Medical 4a. Facility Nama (If not institution, giva streat and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Cumberland Nursing Home Cumberland Allegany If Undar 1 Yaar | If Undar 24 Hrs. | 8. Data of Birth (Month, Day, Yaar) 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1 □ M 2 F Yrs. Director 217-10-1384 78 March 2, 1921 Pennsylvania Usual Rasidance of Dacedan 10a Stata 10h County 10c. City, Town or Location ns 23a or 28a-f show 10d. Inside City Limits 1 Yas 2 No Bedford Hyndman Director Pennsylvania 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 199 Hyndman Road 15545 United States Funeral death Homs 2 11. Marital Slatus 12. Was Dacedant Evar in U,S. Armed Forcas? Was Dacedanl of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. traumatic event, the Medical Examiner Peges 1 and 2 should be filed within 72 hours efter 1 ☐ Navar Married 2 Married 1 TYas 2 No Baltimore, Maryland 21215-0020 ò 1 ☐ Yas 2 MNo Specify: White by Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education 16b. Kind of Businass/Industry (Spacify only highast grada complated) al Hygiene. Elamentery/Secondery (0-12) College (1-4or 5+) 8th Homemaker Home tent of Health end Mental Hy N: If Item 27 is marked other V or other **** 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumeme) Benjamin E. Emerick Mabel Poorbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zlp Coda) 317 Church Street Hyndman, Pennsylvania Faith Horner/Daughter 20b. Pieca of Disposition (Nema of cematary, cramatory or other place) December 15, 1999 Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from Stata 4 □ Donation 5 □ Othar (Specify) permit. Pege Depertment of Important: If eny injury or once. Palo Alto Hilltop Cemetery Hyndman, Pennsylvania 21. Signatura of Funaral Sarvica Licensaa 22. Nama and Addrass of Facility Harvey H. Zeigler Funeral Home 23a. Part1. Enlar tha disaasa, or complications that causad tha daath. Do not enter the mode of dying, such a causa or despiratory anast, shock, or haart feilura. List only one cause on each line. Approximata Intarval Batwe Physician /Medical Immediata Causa (Final accident Cerebrovascular disease or condition rasulting in deeth) Examiner Der tension or Attanding Physician: The law requires that the deeth certificate be executed Sequantially list conditions, if any, laading to immadiate causa. Enter Undarlying Cause (Disaasa or injury that initiated events rasulting in daath) Last pue buriel-tran Dua lo (or es e consaquence of) Division of Vital Records, P.O. Box 68760. ettending physician Physician/Medical Dua to (or as a consequence of): signed by the elid be detected for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Was an autopsy parlormad? Wara autopsy findings available prior to complation of ceuse of death? certificate hes 1 Yas 2 No Be 25. Was case refarred to medical 26. Placa of Death (Check only ona) axaminar? Other: 4 Nursing Homa 5 Rasidance 8 Othar (Specify) npatiant 2.04/Outpatient 3 DOA 10 1 Yas 2 No After this 27. Menner of Death Certification: 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Panding invastigation 1 Naturai death. 1 ☐ Yas 2 ☐ No efter death 2 Accident 6 Could not ba determined 3 ☐ Suicida 28a. Place of Injury - At home, farm, streat, factory, office building, atc. (Specify) 281. Location (Streat and Number or Rural Routa Number, City or Town, Steta) filled in by 4 Homicide within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the Dasis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29e. Cartifiai Medical (Check only one) the 29b. Signature and title of cartifle 29d. Dala signed (Month, Day, Year) 29c. Licansa number December 15, 1997 3 30. Name and address of person who complated causa of daath (Itam 23a) (Type, Print)

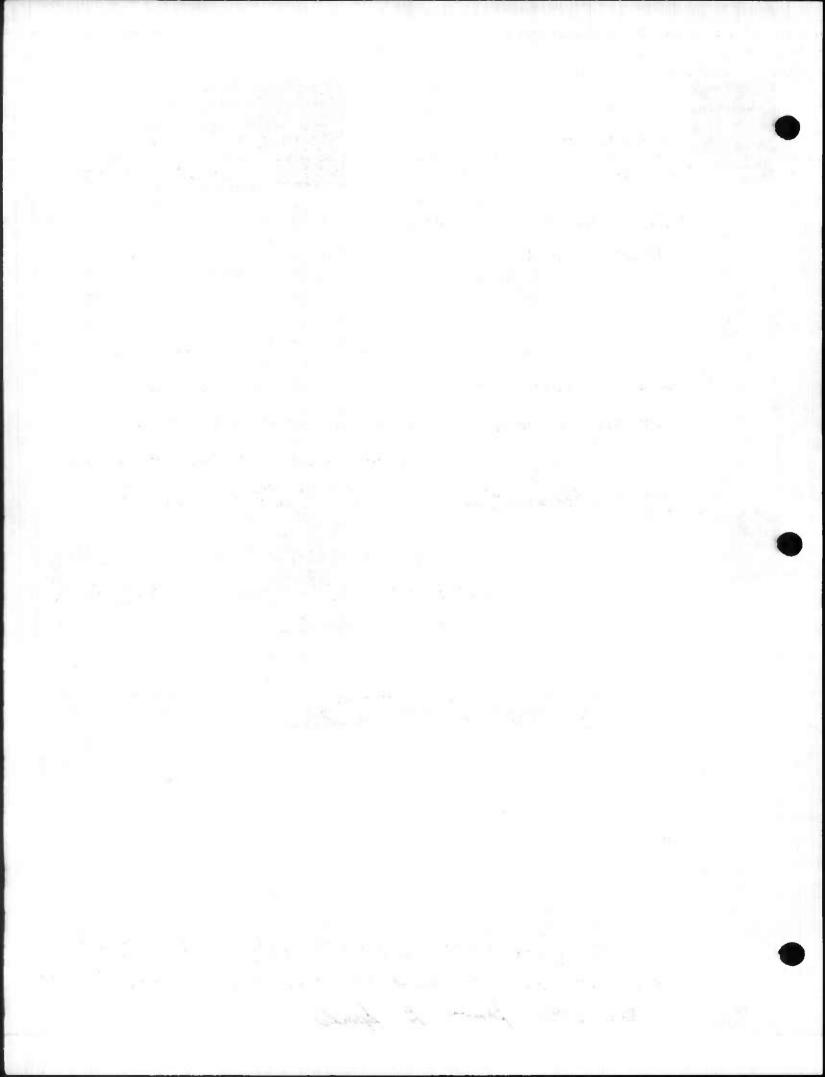
DR. Poonai 920 National LaVale, MD 21502 National 31. Dala filed (Month, Dey, Year) 32. Ragistrar's Signatura State DEC 2 2 1999 Registrar

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State of Maryland / Department of Health and Mental Hygiene 99 41675

					Ce	ertificate of	f Death		Reg. No.		71010
	Dhusia	ian	1. Decedent's Name (First, Middle	, Last)				2. Date o	f Death	Voor	3. Time of Death
	Physic /Medi		Joseph	Aloysius		ngly		DECEM	BER 28	'I'999	9:30 AM
A.	Exami		4a. Facility Name (If not institution		7)			own, or Location of E		ty of Death	
			St. Mary's Hos	·		Williams 1 Van		rdtown	St.	Mary'	
L	Funeral Director		5. Social Security Number 220-34-2932 Usual Residence of Decement	6. Sex 7. A 1)☑ M 2□ F	83 Yrs.	Months Day		Min. Januar	Birth Day, Year) y 2, 1916	9. Birthp Coun Mar	place (State or Foreign oftn) Yland
	land w		10a. State 10b. County		10c. City, Town or L	ocation				1	Od. Inside City Limits
	the Meny 28a-f ah	ector	Maryland St. N	lary's	n	1 ☐ Yes 2/∏ No					
	ath with 23e or	ral Dir	41490 Charles S	treet		10f. Zip Code 206	50		10g. Citizen of		itry?
21215-0020	within 72 hours efter death with the Meryland ene. than "naturel; or items 23a or 28a-f show he Medical Exercices must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marr 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces ed 1 X Yes 2 If Yes, Give Year or Dates] No	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		igIn? (Specify Yes o n, Puerto Rican, etc. :		ace - Americ ack, White, ify: Whi	efc.
5-0	72 ho	eted	15. Decadent (Specify only highes	's Education	16a. Deci	edent's Usuai Occ e kind of work don	upation e during mos	st of working	16b. Kind of	Business/Inc	dustry
121	vithin han	Completed	Elementery/Secondary (0-12)	6 years	life	DO NOT use retin	red)		Circu	it Cou	ı w t
	filed v Hygie fther t	ပိ	17. Father's Name (First, Middle,			ouuge	10 Math	er's Name (First, Mi			11.0
Maryland	2 should be filed within 72 hours end Mental Hygiene. Is marked other than "natural", aumatic event, The Med cal Exa	To Be			lattingly				enedicta	,	Abell
ary	should nd Men marke umatic	F	19a. Informant's Name/Relations	<u> </u>		ing Address (Stre		er or Rural Route N			
	1 and 2 s Health er em 27 is		Mary O. Matting	ly (Spouse)	P.O.	Box 40,	Leona	rdtown, M	aryland :	20650	
altimore,	20 0 2		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		20b. Placa of Disp cametery, cre Our Lady's			Date 12/30/19	20c. Location 99 Leonard	,	
Balti	permit. Peg Department Important: It any injury o		21. Signature of Funeral Service I		Á	2. Name and Add	ress of Fecili	diner Fund	eral Home	, P.A	
			23a. Pert1 Enfer the disease, or	còmplications that cause				Leonardto		and 20	U65U Approximete
68760,	requires that the death certificate be executed >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>	cal Examiner	Immediete Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	. Ca	Ole to (or as a gense Due to (or as a gense	ulninguence of:	Dis	trass &	yndro	na	Joays Luk Ways
Box 68	h certificet anding phy use as th	in/Medical	resulting In death) Last	d	Due to (or as a conse	quante ory.					0
O. B	that the death cer ed by the ettendin deteched for use	Physician	Part II. Other significant condition	ns contributing to death	but not resulting in the	underlying cause o	given in Part I	l. 23b.	Did tobacco use c	ontribute to	o the cause of death?
Δ.	es that the igned by be detected	by Ph	Co	ronary	pus	ux	2		1 □ Yes 2 5 No	3 Prot	bably 4 ☐ Unknown
Records,		Completed b				/	•	24a. \	Vas an autopsy performed?	ava	ere autopsy findings aliable prior to impletion of cause death?
Ä	0 - 0	E O							Yes 2. No	10	Yes 2 No
Vital	ysician: The s certificate director, pag	Be	25. Was case referred to medical examiner?				26. Plece	e of Death (Check o	nly one)		
of V	5 00	2	1 ☐ Yes 2 No	Hospital: 14 Inpat		ent 3 DOA	ther: 4 Nu	ursing Home 5 🗆 F	Residence 6 🗆 O	ther (Specify	у)
	Ing Ph	ion:	27. Menner of Death 1 Natural 5 □ Pending		lury 28b. Time lay Year) Injury	W			tbe how Injury occu	irred	
Division	To the Hospital or Attending F within 24 hours effer death. To the Funeral Director: After completely filled in by the funer	Certification:	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot he	njury - At home, farm, s etc. (Specify)		Yes 2 🗆	28f. Locati	on (Street and Num Town, State)	nber or Rura	al Route Number,
ī	To the Hospital or within 24 hours ette To the Funeral Direction completely filled in	edical C	29a. Certifier (Check only one) 1 Certifying 2 Medical E	p Physicien: To the best	of examination end/or le	th occurred et the nvestigetion, in my	time, date er oplnion, dee	nd piece, end due to ath occurred et the ti	the cause(s) and me, dete and place	nanner as st	tated. the ceuse(s)
	vithin To the	Me	29b. Signature and title of cartifier	1)/	Market.	29c. Lice	nse nu <i>m</i> ber		29d. Date sig	ed (Monthy)	Day, Year)
	. > - 0		1 Am	* there	2 HAS	75	064	419	12/	29/9	19
			30. Neme end address of person v	who completed cause of	death (item 23a) (Type	, Print)			Mys	0/1	/
			JAMES P JARBOI	M/D. PH	ILIP J.BEA	MEDICAL	L CTR.	P.O.BOX6	40 HOLLYV	100D,M	Ď. 20636
	Sta * Registi		31. Date filed (Markin, Day, Year) DEC 2 9		trar's Signature	Sport	2				



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** JANE LEE MEANYHAN DECEMBER 21, 1999 0500 AM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SACRED HEART HOSPITAL CUMBERLAND ALLEGANY If Under 1 Yeer | If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Sociel Security Number 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Months 1□M 20 F Yrs. 213 64 9467 Director OCT 10 1953 MARYLAND Usual Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow. Yes 2 No 28a-f Directo MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 135 SPRING STREET 21532 U.S. Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Maritei Stetus Bleck, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Merried 2 ☐ Merried 8 altimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: Specify: 3 ☐ Widowed 4 ☒ Divorced Year or Detes WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) t5. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ed other than event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit Department of Health and Mental H Important: If Item 27 is marked oth any Injury or other traumatic even Be EDWARD J. HOUSE, SR. BETTY SKIDMORE 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) STACIE L. ZELENKA / DAUGHTER 8285 ELAINE WAY, FREDERICK, MD 21704 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetton 5 ☐ Other (Specify) FROSTBURG MEMORIAL PARK 12/23/99 FROSTBURG, MD 21532 21. Signet re of Funeral Service Licensee 22. Name end Address of Fecility
SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, rone cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical immediate Cause (Finel disease or condition resulting in deeth) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last and P.O. Box 68760. Physician/Medicai Due to (or es a consequence of): 9SN Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Erosine Esophagetis 1 Yes 2 No 3 Probably 4 Unknown Records. ģ Be Completed Extensive Calonic angiodepplia with blading 24b. Were autopsy tindings available prior to 24a. Wes an eutopsy performed? completion of cause of death? 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this funeral 28e. Dete of Injury (Month, Day Year) 27. Menyler of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of After 1 Neturel 5 Pending within 24 hours after death.
To the Funeral Director: Al completely filled in by the fu 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Pleca of injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Hospital 29e. Certifier Medicai 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the cause(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner steted. the th 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signeture end title of certifier m D 3 DECEMBER λ , 1999 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 5 SATURNINA- CHANG M.D. 10701 New George Creek S.W. Fras Thung Maryland 21532 31. Dete tiled (Month, Dey, Year)

State Registrar

DEC 23 1999

32. Registrer's Signeture

and I must some to opening

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Date of Death Yea Month William McFarland John 27, 1999 11:22 am December 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Memorial Hospital Cumberland 8. Data of Birth (Month, Day, Year) Aug 23, 1932 5. Social Security Number 7. Aga (In yrs. last birthday) If Under Yaar If Under 24 Hrs. Days Hours Min. Birthplace (State or Foreign Country) Days Months 10M 20F 67 216-30-3074 Yrs Usual Rasidanca of Dacedani 10a. Steta 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yas 2 No Allegany LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1240 Braddock Road West 21502 USA 12. Wes Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 14. Bace - Amarican Indian 11 Merital Status Bleck, White, etc. 1 Tas 2 No if Yas, Give Year or Dates: 1 Never Merried 2 Married 1□ Yas 2□No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) retired Policeman MD State Police 17, Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Surnama) Daniel Willard McFarland Eula F (Smith) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 1240 Braddock Road W; LaVale MD 21502 19a. Informant's Name/Reletionship (Type, Print) Margaret McFarland 1240 Braddock Road W; LaVale 208. Memod of Disposition 20b. Plece of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, State 1 Durial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Sunset Memorial Park 12/30 Cumberland, MD 21. Signeture of Funeral Service Licenses 22 Scarperii Fineral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one deuse on each line. Approximata Interval Between Onset and Death immediata Cause (Final disease or condition resulting in deeth) e Ventricular Fibrillation Hour Dua to (or as a consequence of) Coronary Artery Disease 7 years Sequentially list conditions, If any, leading to Immadiate cause. Entar Underlying Cause (Disaase or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of) Sepsis 3 weeks Dua to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Renal Failure 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No t ☐ Yas 2 ☐ No 25. Was casa rafarrad to medical examiner? 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 M Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27 Mannar of Death 28b. Time of Injury 28c. Injury et Work? 28d. Dascribe how Injury occurred 1 Natural 5 Pending invastigation 1 Yas 2 No

sician and burial-transit The lew requires that the death certificate be executed physician as the burial-Records, P.O. Box 68760, should page 2 s After this certificata hes Division of Vital or Attanding Physician: director, John McFarland funeral deeth. within 24 hours after deet To the Funeral Director:

216-30-3074

Examiner Physician/Medical à Completed Be

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

should be filed within 72 hours after and Mental Hygiene.
marked other than "natural", or hei

permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy important: If flem 27 is marked other any hijury or other traumatic avent state.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

à

Completed

Be

MD

the Maryland

Certification: To

Medical completely 3

filled in by

Hospital

the

State

Registra

30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print) Dr. Vik Poonai

29a. Cartifier

2 Accidant

3 ☐ Suicide

4 Homicida

(Check only one)

29b. Signature end title of certifie

31. Dete filed (Month, Day, Year) DEC 28 1999

6 Could not be determined



920 National Highway

28e. Pleca of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D36766

29c. License number

LaVale, MD

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

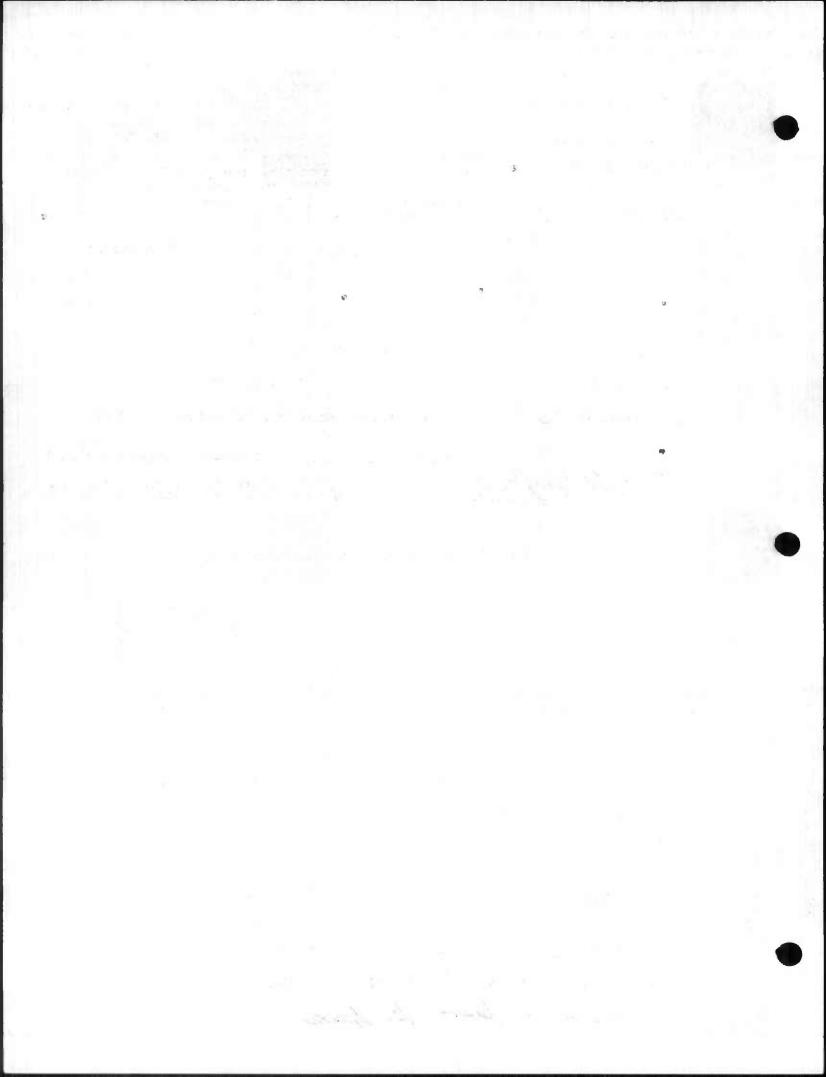
29d. Data signad (Month, Day, Year) December 27, 1999

G. 1. 1998 S. 1998

		Decedent's Neme (First, Middle, L			Certific			10 Mental Hy	Reg. No.	19 [3. Time of Death	
Physici /Medic		Oceanata Rachel						DECEM!	BER 08,	1999	05:30AM	
Examin	ner	4e. Fecility Neme (If not Institution, g St. Mary's Hosp		r)				n, or Location of Deel nardtown		Mary	s	
Funeral Director		579–18–0325	Sex 7. A 1 □ M 2 ■ F	nge (In yrs. lest 78	birthday) If Ur Yrs. Mont	der 1 Year hs Days		Min. 8. Date of Bi (Month, Danuary	8, 1921	9. Birthpl Count Louis	ece (State or Foreig ry) SIANA	
and we		Usuel Residence of Decedent 10a. Stete 10b. County		10c. City, T	own or Location					10	Od. Inside City Limits	
ith the Marylen or 28a-f show or nottined at	tor	Maryland St. Mary's Lexington Park						1 ☐ Yes 2 ■ N				
th with the 23a or 28	Funeral Director	10e. Street end Number 47931 Mattapany	Road		10f.	Zip Code 2065	3		10g. Citizen of United			
permit. Peges 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23a or 28e-f show eny folgury or other treumstic event, The Medical Examinat must be notified at once.	by	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Deceden Armed Forces 1 Yes 2 ff 1 Yes, Give Year or Dates	No		Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:				ce - America ck, White, e	etc.	
natur	etec	15, Decedent's I (Specify only highest g	ducation rade completed)	1	6e. Decedent's U	suel Occu work done	petion during most o	f working	16b. Kind of B	usiness/Ind	ustry	
iene. then	Completed	Elementery/Secondery (0-12)	College (1-4or	r 5+)		naker			n	/a		
Jid be filed Aental Hyg rkad other tic event,	To Be C	17. Fether's Name (First, Middle, Las Oscar F. Bailes:	*					Neme (First, Middle a E. Brewe	irst, Middle, Maiden Surneme) Brewer			
and 2 shorestith end No. 27 is mail		19a. Informent's Neme/Relationship Ann Papson, Daugh		4	19b. Mailing Addi 14120 Lo	ess (Stree uis D	ale Rd.	or Rurel Route Numb	per, City or Town Tnia, MD	Stete, Zip 206		
Peges 1 ment of He ant: if Item ury or oth		20a. Method of Disposition 1 Buriel 2 Cremetion 3 4 Donetion 5 Other (Spec		ceme	of Disposition (etery, crematory James C	emete	ry	Dete 12-11-99		ton Pa	ark, MD	
Departition Depart		Edward N. Bri	nstield,JR	.,M0005	22. Name 52 2295	and Addr	ess of Fecility Lywood	Brinsfield Rd., Leon	l Funera ardtown	l Home	P.A. 20650-027	
		23a. Part1. Enter the diseese, or con shock, or heert feilure. List onl	nplicetions that cause y one ceuse on each	ed the death. [Do not enter the r	node of dy	ing, such es ca	rdiac or respiretory	errest,		Approximete Intervel Between	
Physician /Medical Examiner	er	Immediete Cause (Final diseese or condition resulting in deeth)	· Man		e consequenca		nial	bleed			onset end Deeth	
eath certificete be executed ettending physician and for use as the buriel-trensit	an/Medical Examiner	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest	c		e consequence							
the ett	Physician/M	Part II. Other eignificant conditions	contributing to death	but not resultin	g In the underlying	g cause gi	ven In Pert I.	23b. Did	tobacco uee co	ontribute to	the causa of death	
es that the de								1 🗆	Yes 2 No	3 Prob	ably 4 Unknow	
The law requires that the death certificate has been signed by the ettending page 2 should be detached for use a	Completed by							24e. Wes	s en eutopsy ormed?	con	re eutopsy findings ileble prior to apletion of cause leeth?	
The law ate hes page 2	Com							1 🗆	Yes 2 No	1□	Yes 2□ No	
lcien: The I certificate he rector, page	Be	25. Was case referred to medical examiner?	Hospitel:		-	0	26. Place o	Death (Check only	one)			
hys digital	n: To	1 ☐ Yes 2 ☒ No 27. Menner of Deeth	28e. Dete of Inj	iury 28	b. Time of	DOA	4 LINUIS	ing Home 5 ☐ Res 28d. Describe)	
To the Hospital or Attanding Physician: within 24 hours after death: To the Funeral Director. After this certified completely filled in by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not determine	20		b. Time of Injury M 28c. Injury et Work? M 28d. Describe how injury occurre Work? 1 □ Yes 2 □ No 28f. Location (Street and Number City or Town, Stete)				ber or Rurei	Route Number,		
d hours aftuneral Di cuneral Di ely filled in		(Uneck only 2 Medical Exa	hyeiclan: To the best	t of my knowled	dge, death occur	ed et the ti	me, dete end	plece, end due to the	ceuse(s) end m	enner es st	eted.	
ithin 2 or the P	Medicai	one) 29b. Signature end title of cartifier	end menner s	steted.			se number	T	29d. Date signe			
848		5 C Gal	4	M.D.		_	434	. 6	12/8			
		30. Neme end eddress of person who		deeth (Item 23			206		10	, , ,		
Stat Registra		31. Dete filed (Month, Day, Year) DEC 13	32. Regist	trer's Signeture	,	door		.50				

OCEANTA RACHELL OLIVER

NAME:



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey Physician Dec 28, 1999 Raymond Osbourne 02:15am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 1512 G Old Towne Manor Cumberland Allegany 8. Dete of Birth (Month, Day, Year)
Apr 4, 1923 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Funeral Days Hours Months 10M 20 F MD Yrs. 216-14-1877 76 Director Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Director Allegany Cumberland notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? finer must be n Will 1512 G Old Towne Manor 21502 USA Funeral 12. Was Decedent Ever in U,S. Amoed Forces? 1 Å Yes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) al Hygiena. John Than Tnatural, or herns event, the Medical Examiner or 14. Rece - American Indien, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2☐ No Specify: Specify: white ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retired Letter Sorter U.S. Postal Svc Pages 1 and 2 should be filed w timent of Health and Mental Hygies famt: if Item 27 is marked other to jury or other traumstic event, ID; 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) å nfn Florence (nmn) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1512 G Old Towne Man; Cumberland, MD 21502 19a. Informant's Name/Relationship (Type, Print) Josephine Osbourne Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 Cremation 3 ☐ Removel from State Department of Important: If any injury or ance. 4 ☐ Donation 5 ☐ Other (Specify) Scarpelli Funeral Home12/29 Cresaptown, MD 22 Scarperii Fineral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical HENNET ONE WHER CONFESTIVE Examiner Due to (or as a consequence of) Examiner OWE YOUR CURDNANT ANTENY DIJENSE The lew requires that the deeth certificate be executed anding physicien end use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown PURIPHENAL VASCULAR DISCHIE of Vital Records, à pege 2 should b 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy performed? Completed this certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 8 25. Was case referred to medical examiner? 26. Piece of Deeth (Check only one) 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury et Work? After 5 Pending investigation Division 1 Shatural 2 Accident I Director: Aft of in by the fur 1 Yes 2 No 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital of within 24 hours of To the Funeral Completely filled I Hospital 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of perifficient Dec 28, 1999 3 D33417 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James R. Moen M.D. 1068 National Highway LaVale MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 28 1999

DHMH 16 Rev 6/95

Registrar

Grane to operate

min x C . - !

State

200. Square end little of certifier

and address of parson who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Registrar

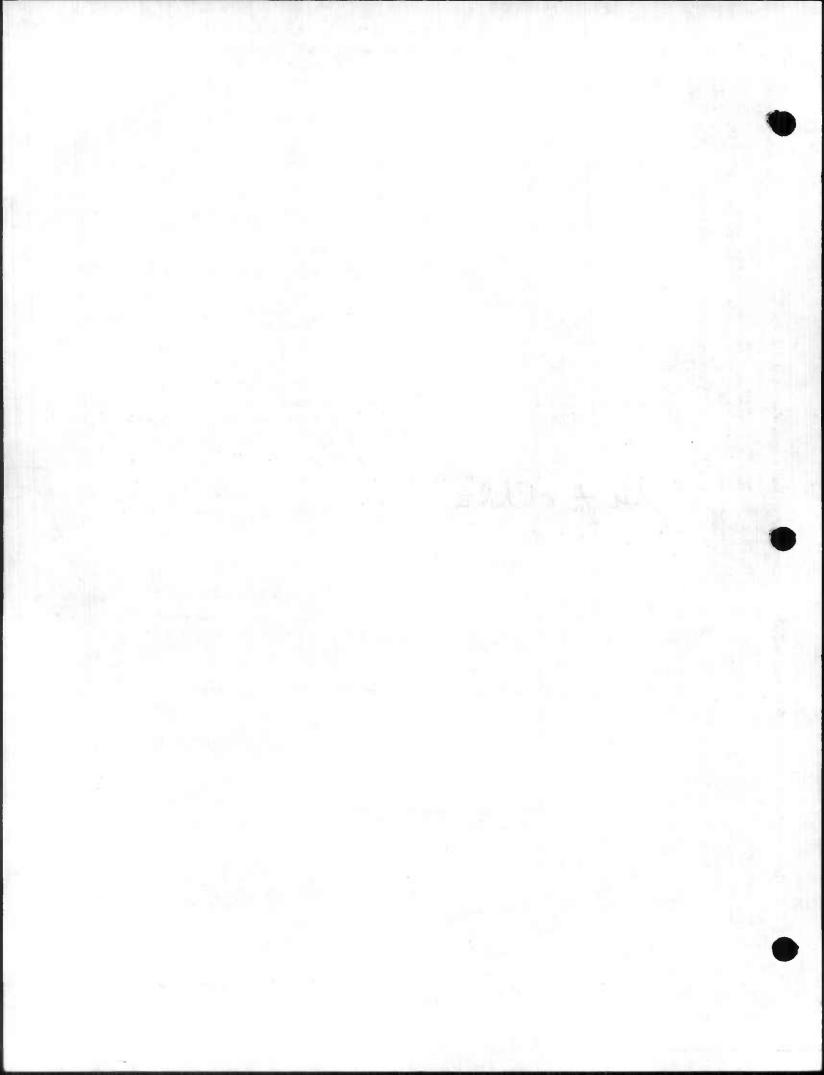
29c. License number

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

December 23, 1999



permit. Pages 1 and 2 should be filed within 72 hours eiter death with the Marylan Depertment of Heatil end Mantal Hygione. Important: if item 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic event, the Madical Experiment matter to conflined a

sician end buriel-transit

physician the buriel

signed by t

hes

After this certificate

funeral

filled in by

29b. Signature and title of cartifier

30. Name and address of person

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice

To the Hospital within 24 hours a To the Funeral D

Box 68760.

P.O.

Records,

Division of Vital

the Maryland

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 06, 1999 **Physician** Paul Edward Rodine 11:15PM /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day) 5. Social Security Number Birthplace (State or Foreign Country)
 China 7. Age (In yrs. last birthday) **Funeral** Deys 1 ■ M 2 □ F 562-26-6681 74 Yrs. Director December 22, 1924 Usual Residence of Decedent 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland St. Mary's Hollywood 1 ☐ Yes 2 ■ No Director 10f. Zip Code 20636 10e. Street and Number 10g. Citizen of What Country? 43348 Riverside Drive United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Rece - American Indian, Black, White, etc. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ■ Married 1 ■ Yes 2 □ No If Yes, Give W Year or Dates: 1 ☐ Yes 2 ■ No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Salesperson Oil Industry 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hugo Gustaf Rodine Ruby May Nordin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 43348 Riverside Drive, Hollywood, MD 20636 Mary Ellen Rodine, Wife 20b. Placa of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, State Mt. Zion Cemetery 1 Burial 2 Cremation 3 Removal from State 12-10-99 Mechanicsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brigsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650-0279 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death **Physician** /Medical Immediate Ceuse (Final a. Paucy + penta Dub to (or as a consequence of): disease or condition resulting in death) Examiner Clarent lynghocytic Louhenia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or es e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveileble prior to completion of cause Completed 24e. Wes en autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 WNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Placa of Injury · At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and menner as steted.
2 Madical Examinar: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date end placa, end due to the ceuse(s) and manner stated. 29e. Certifier

29c. License number

001380

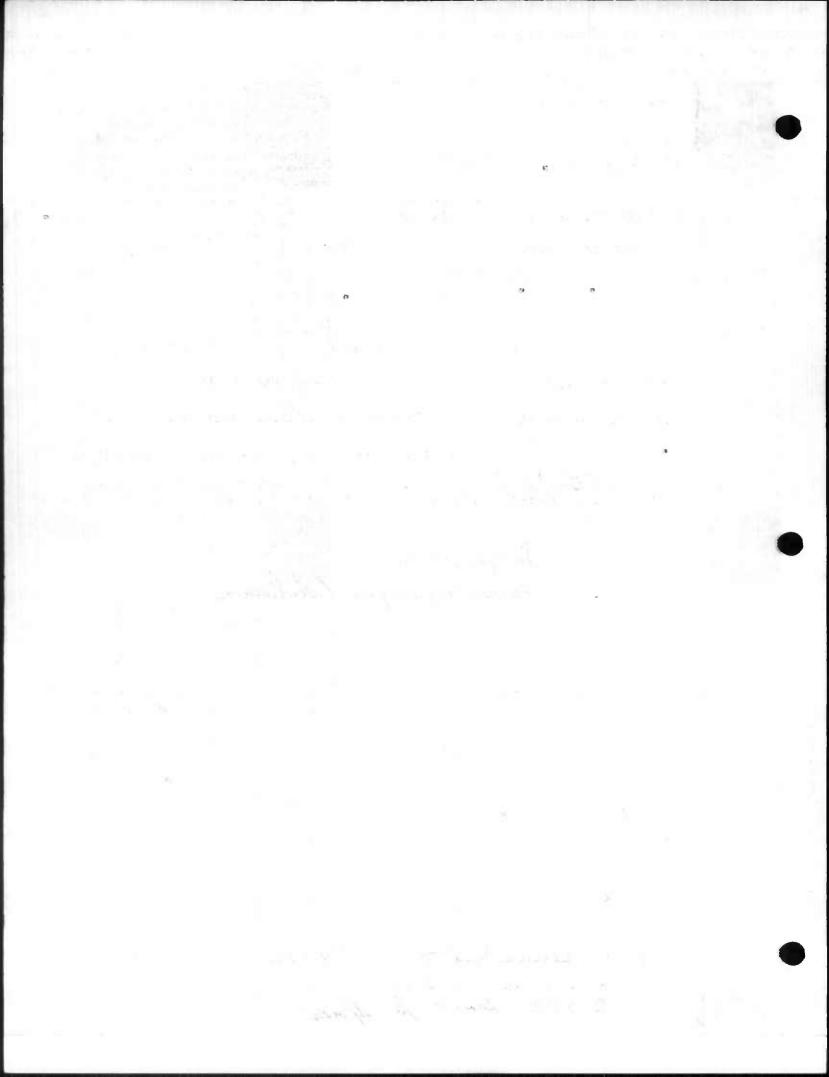
29d. Date signed (Month, Day, Year)

State

HOLLYWOOD, MD. 20636 JOHN F. FENWICK 31. Date filed (Month Pay 32. Registrar's Signature

who completed cause of deeth (Item 23a) (Type, Print)

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death C 1. Dacedant's Nema (First, Middla, Last) 2. Data of Death 3 Time of Death December 2, Day 1999 **Physician** Jon Whitney Smith 5:25 PM ELEMBER /Medical 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Charlotte Hall Veterans Home Charlotte Hall St. Mary's If Undar 24 Hrs. 5. Social Sacurity Numbar If Undar 1 Yaar 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foreign Country) **Funeral** Months Days Hours 1√ M 2□ F 577-56-3685 Yrs Director February 12, 1941 Washington, DC 58 Usual Rasidance of Dacedant Maryland 10a Stata 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, one Madical Examer mast be notified at 10d. Insida City Limits 1 Yas 2 No Director Florida Sarasota Venice the 10a. Street and Numbar 10f. Zlp Coda 10g. Citizan of What Country? 891 Seneca Road 34293 USA Funeral (Snuffy) 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status 12. Was Dacadant Evar in U,S. I ☑ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 Navar Marriad 2 Marriad Baltimore, Maryland 21215-0020 Specify: White by 3 ☐ Widowad 4 ☑ Divorced Completed 16e. Dacedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Dacedant's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Coltage (1-4or 5+) Hygiena. Firefighter 12th Grade Fire Department 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meidan Sumama) 12 should be fi h and Mental H Is marked ott Clifton Blain Smith Wilma R. Whitney 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Smith, Important: If item 27 is n 30123 Shoreview Drive, Mechanicsville, Maryland 20659 Erin Lyn Hayes (Sister) 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory 12/5/1999 Alexandria, Virginia 21. Signatura of Funeral Sarvice Lipens 22. Nama and Addrass of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650 aine 23a. Parti. Entar tha disaasa, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or heert faiture. List only one cause on each line. Approximeta Intarval Between Onsat and Death **Physiclan** myotrophic Lateral Sclensis
hort term memory LOSS /Medical Immediata Ceuse (Final diseasa or condition resulting in daath) Examiner Examiner be axecuted Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaasa or Injury that initiated avants resulting in daath) Last and P.O. Box 68760, physician Physician/Medical the Dua to (or as a consequence of): for use es the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yas 2 ☐ No 3 ☐ Probably Unknown Records, ρ 24a. Was an autopsy performad? 24b. Wara autopsy findings availabla prior to complation of causa of death? Be Completed ate has certificate 1 Yas 2 No Division of Vital 25. Was casa referred to medical 26. Placa of Daath (Chack only ona) Othar: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 10 1 ☐ Yas 2 ☐ No / S effer dea. 1 Inpatiant 2 ER/Outpatiant 3 DOA 28e. Deta of Injury (Month, Day Year) Mapner of Deeth 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: or Attending Neturel 2 Accident 5 Panding investigation 1 ☐ Yas 2 ☐ No 6 Could not be datarminad 3 ☐ Suicida 28e. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicida To the Hospital within 24 hours e To the Funeral Completely filled Hospital Medical 1X Cartifying Physician: To the bast of my knowladge, deeth occurred at tha tima, data and place, and dua to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, deta and place, and dua to the cause(s) and mannar stated. 29a, Cartifian 29b. Signatura and titla of certifiar 29c. Licansa numbar 29d. Data signad (Month, Dey, Yeer) and addrass of person who completed cause of daath (Itam 23a) (Type, Print) #204, PRINCE FREDRICK, MD 20638

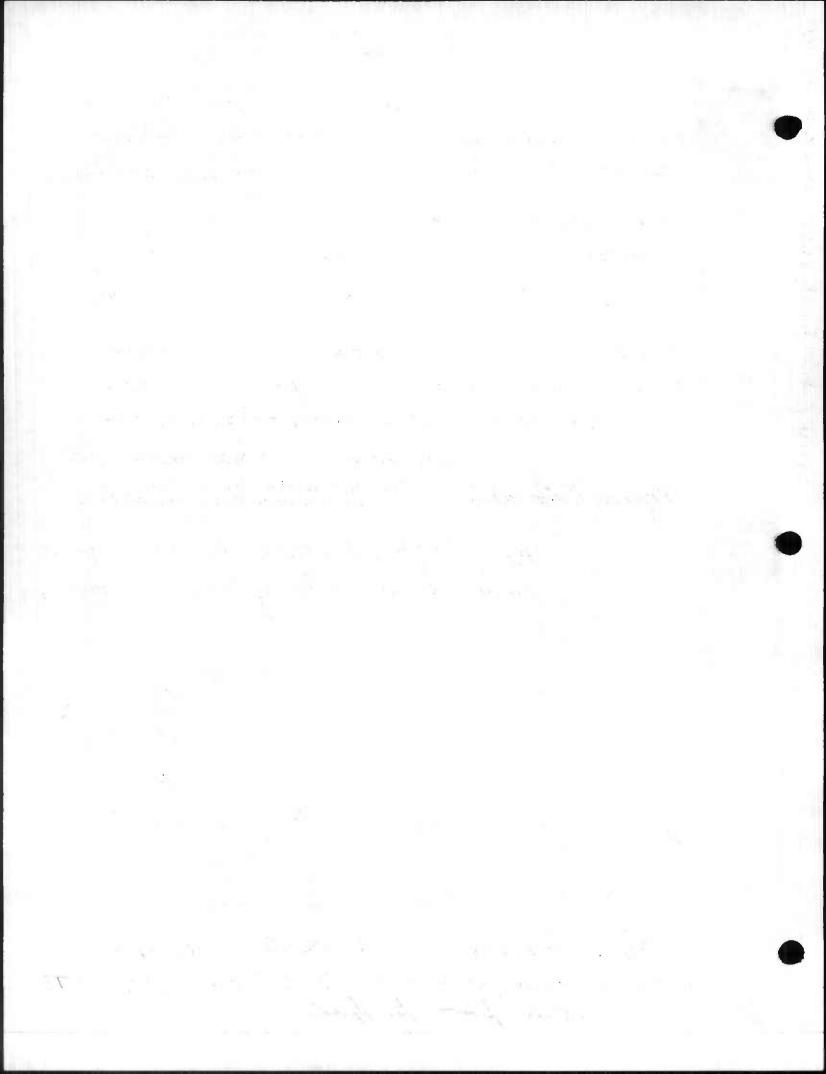
Suite 32. Ragistrar's Signatura

Registrar

State

31. Date filad (Month, Day, Yaar)

6



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dey **Physician** John December 6, 1999 Edward Sumstine 1:15 p.m. /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Tall Timl If Under 24 Hrs. 17731 Clarke Road Timbers St. Mary's If Under 1 Yeer Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Dete of Birth (Month, Day, Yaar) **Funeral** Months Deys Hours Min. 1■M 2□F Yrs. Director 578-24-6066 86 July 22,1913 Dist. of Columbi Usual Residenca of Decedent with the Manyland 10a State 10b County 10c. City, Town or Location 10d. Insida City Limits 7 is marked other than "natural", or items 23s or 28a-f show treumetic event, the Modical Examine, must be notified at 1 Yes 2 No Director Maryland St. Mary's Tall Timbers 10e. Sireet end Number 10f. Zip Code 10g. Citizen of Whel Country? 17731 Clarke Road Funeral 20690 United States death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give Race - American Indien, Bleck, White, etc. 11. Marital Stelus Was Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 Divorcad White Completed 16e. Decedent's Usual Occupetion (Give kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) al Hygiena. Collega (1-4or 5+) Elemantary/Secondery (0-12) Supervisor, Public Works U.S. Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surneme) permit. Pages 1 and 2 should be f Depertment of Health and Mental F Important: If Item 27 Is marked of any Injury or other treumatic eve Edward Bernard Sumstein Catherine Louise Kober 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 17731 Clarke Road, Tall Timbers, Maryland 20690 Joan L. Farrar/ Daughter 20b. Place of Disposition (Nama of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Othar (Specify, Metropolitan Crematory 12/7/99 Alexandria, Virginia 21. Signature of Juneral Bervice Licensee 22. Name and Address of Facility Brinsfield Funeral Home Bringfeld, Jr M00052 22955 Hollywood Road, Leonardtown, MD 20650-0279 Edward N. 23a. Pert1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. **Physician** /Medical Immediete Cause (Finei disease or condition resulting in death) Examiner Examiner physician and the buriel-tren Sequentially list conditions, if eny, laading to immediata causa. Enter Underlying Cause (Diseese or injury that initiated events rasulting in daath) Lest Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 80 950 Por Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? been signed by the s 1 Yes 2 No 3 Probably 4 Unknown p 24b. Wera eutopsy findings eveilable prior to 24a. Was en autopsy Completed completion of cause of death? page 2 1 Yes confilicate 26. Place of Deeth (Check only one) å 25. Was case referred to medical examiner? Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) Injury et 28d. Describe how injury occurred Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 결 27. Mennar of Deeth 28a. Date of injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Certification: After Division 5 Panding invastigation 1 aturai 1 Yes 2 No 2 Accidant after deat Director: 6 Could not be datarminad 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Pieca of Injury - At home, farm, straet, factory, office building, etc. (Specify) 4 Homicida To the Hospital o within 24 hours at To the Funeral Di Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to tha cause(s) and mannar as stated. Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to tha cause(s) end manner stated. edical 29a. Certifie (Check only one)

State Registrar 31. Dete filad (Month, Dey, Yeer) nfr - 9 1999

30. New and address of parson who complete a wayse of death (Item 23a) (Typa, Print)

29b. Signetura and titia of certifier

dames C. Boyd, M.D.,

32. Registrar's Signeture

23415 Three Notch Rd., California, MD 20619

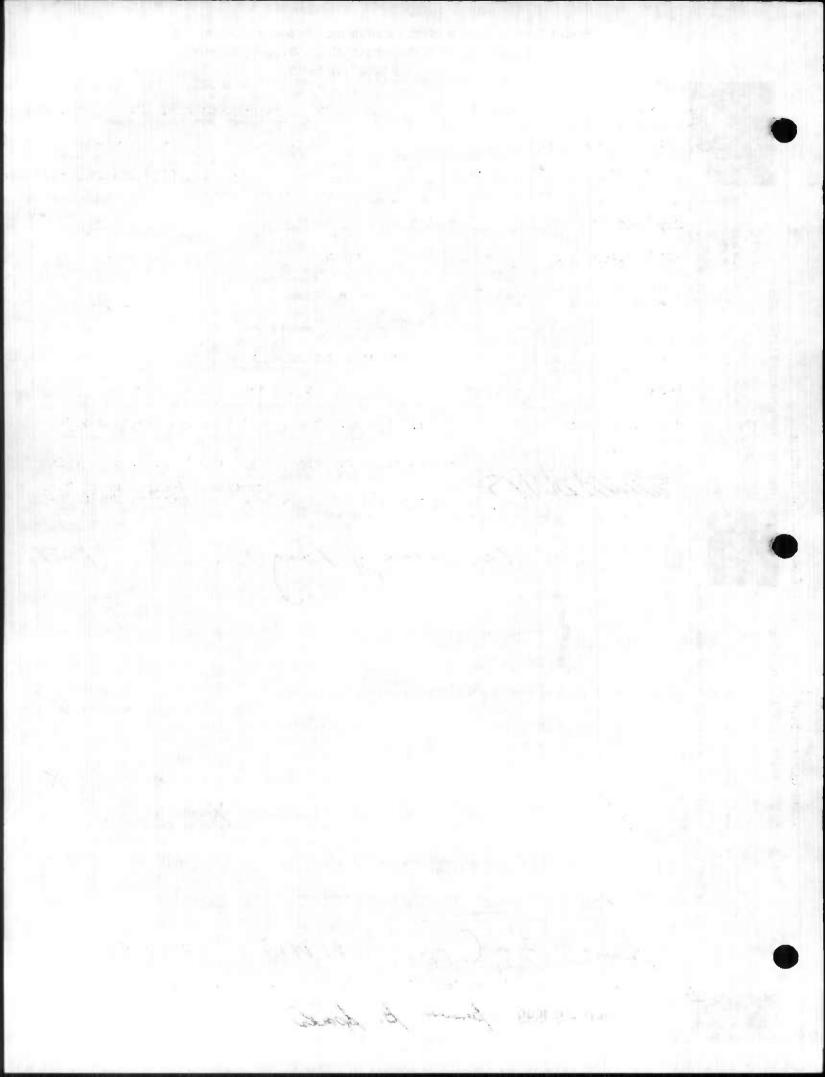
29c. License number

29d. Date signed (Month, Dev. Year)

99

John Sumtine

John Edward Sumtine / (aka)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 2. Data of Death

Physician /Medical **Examiner**

10:30PM

10d. Inside City Limits

1 Yas 2X No

Funeral Director 9. Birthplaca (Stata or Foraign Indiana

Director

Funeral

by

Completed

28a-f show 6 items 23a 72 hours after

treumstic event, the Medical Examiner must be notified at "natural", or

Physician

Baltimore, Maryland 21215-0020

/Medical Examiner

Examiner

buriel-transit Physician/Medical the sata has been signed by page 2 should be datach Be Completed by this certificata edical Certification: To

P.O. Box 68760, Records, Vital Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certifical
 etely filled in by the funeral director, of Division within 24 hours a

To the Funeral C

completely filled

STATE

FREDERICK

JOSEPH

NAME:

1. Decedent's Nama (First, Middla, Last) Frederick Staten Joseph DECEMBER 16, 1999 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and number) 4c. County of Death Leonardtown St. Mary's St. Mary's Hospital if Undar 1 Yaar 8. Data of Birth (Month, Day, Year) November 16, 5. Social Sacurity Number If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Days 1 € M 2 □ F 307-14-4865 Yrs 1922 Usual Rasidance of Decedant 10a, Stata 10b. County 10c. City, Town or Location Maryland St. Mary's Callaway 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? US 20410 Killdeer Lane 20620 12. Was Decedant Evar In U,S. Armed Forcas? Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Marital Status Race - Amarican Indian, Black, Whita, atc. 1 X Yas 2 □ No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Married 1 ☐ Yas 2 ☑ No Specify: White 3 Widowad 4 Divorced 16a. Dacedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) College (1-4or 5+) Year Minister Church 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maidan Surnama) Frederick Staten Thelma Mae Bunce Robert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 20410 Killdeer Lane, Callaway, Maryland 20620 Marjorie Dee Staten (Spouse) 20a. Mathod of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stata Washington Park-North Mausoleum 1 Burlal 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify)Entombment 12/21/1999 Indianapolis, Indiana 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
P.O. Box 270, Leonardtown, Maryland 20650 21. Signature of Funaral Sarvica Licensee ardenes rechaes 23a. Part1. Enter the disease ocomplications trat caused the day to Do not enter the mode of dylng, such as cerdiac or respiratory errest, shock, or heart failure. Let only one cause on each line. Immadiata Causa (Final disaasa or condition resulting in daath) Sequantially list conditions, if any, laading to Immadiata ceusa. Entar Undarlying Causa (Disaase or injury that Initiated avants rasulting in daath) Last 23b. Did tobacco use contribute to the cause of death?

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.

26. Place of Death (Check only one)

24a. Was an autopsy performad?

2 No

1 ☐ Yes 2 ☐ No

24b. Wara autopsy findings available prior to complation of causa of death? 1 Yas 2 No

3 Probably

4 Unknown

Approximate Interval Batween Onset and Death

25. Was cesa rafarragho medical axaminar? 2 No 27. Mannar of Death

1 Inpatiant 28a. Data of Injury (Month, Day Year) 5 Panding invastigation

2 ER/Outpatiant 28b. Tima of

28e. Place of Injury - At homa, farm, straet, factory, office building, etc. (Spacify)

3 DOA 28c. Injury at Work?

Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 28d. Dascribe how injury occurred

1 Yas

281. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier

1 Natural

2 Accidant 3 Sulcida

4 | Homicida

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to tha cause(s) and manner as stated.
2 Medicat Examine Con the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha ceuse(s) medicat Examine Con the basis of axamination and/or invastigation, in my opinion, daath occurred at the tima, data and place, and dua to tha ceuse(s)

1 Yas

29b. Signatura and title of ceal

6 Could not be

29c. Licansa number

20636

29d. Data signad (Month, Day, Year)

30. Name and addrass of person DR. ADINATH A. PATIL 31. Data filad (Month, Day, Yaar)

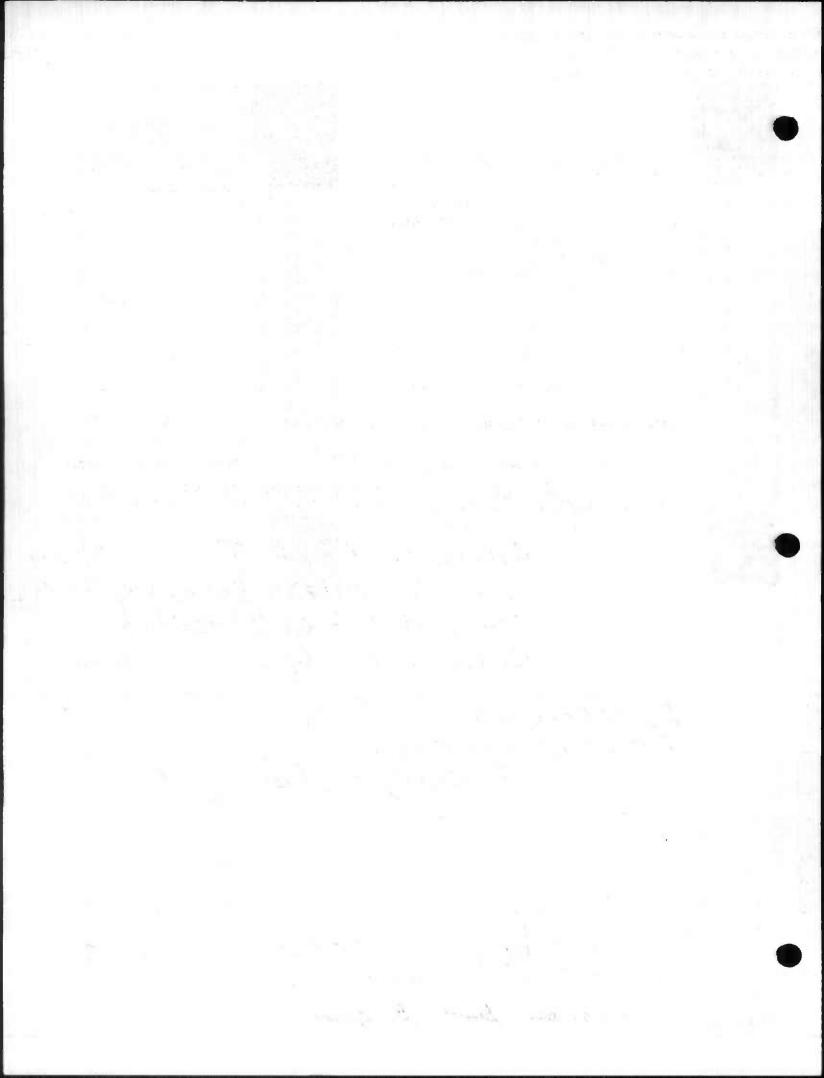
DEC

20

32. Ragistrar's Signature

A. PATIL HOLLYWOOD, MD.

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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					Ce	rtifica	te of	Death			Reg. No.	2	41	000
	1	1. Decedent's Nama (First, Midd	le, Last)							2. Date of De	ath		3. Tim	a of Death
	Physician	Edna Mae Sando	ene							Month December	Day er 17.	1999	2.	20 pm
9	/Medical Examiner	4a Facility Name (If not institutio	n, give street and n	umber)			T	4b. City, To		cation of Deat	1	inty of Death		20 pili
	Lxammer	Memorial Hosp	ital				-	Cumb	erla	nd		Allega	ทบ	
-	Funeral	5. Social Security Number	6. Sex	7. Age (In yrs	. last birthday)		r 1 Year	If Under	24 Hrs.	8. Data of Bir (Month, Da	th .			ate or Foreign
	Director	219-52-0480	1□M 2 % F	53	Yrs.	Months	Days	Hours	Min. O	ctober	20, 19	146 M	ary1	
	Pue Re	10a. State 10b. County	1	10c. C	ity, Town or Lo	ocation				0			10d. Insid	le City Limits
	or 28a-f ahr be notified	Pennsylvania	Bedford	Hyn	dman			15,5						Yas 2□No
	ter death with the Manylan terms 23e or 28e-f show tree must be notified at Funeral Director		t			10f. Zi	p Code 45				10g. Citizen of What Country? United States			
020	Mr. or	3 □ Widowed 4 M Divorced	ried 1 Yas	2 No Giva		Was Dece If Yes, spe 1□ Yes	ecity Cut	an, Mexica	n, Puerto	ecify Yas or No Rican, etc.)	Raca - Ameri Black, Whita ocity: Whi	, atc.	n,	
2-0	netural,	15. Deceder	nt's Education	n	16a. Dece	dent's Usu	al Occu	pation during mos	of worki	na		Businass/Ir		
21	ed within 72 ho ygiene. or then "neture it, the Medical Completed	(Specify only higher Elementary/Secondary (0-12)	7	(1-4or 5+)	life.	DO NOT	use retire	id)	H DI WOIN	ny	Conto	1 Ser		1.00
7	Hygiene. Hygiene. Idher than And, the te	12			Day (Care	Prov	ider			3001	T Sel	vices	5
Maryland 21215-0020	Be aver	17. Father's Nama (First, Middle,								(First, Middle, outman	, Maiden Sun	name)		
7	th and Man T la marke traumate	19a. Informant's Name/Relations	ship (Type, Print)		19b. Meili	na Addres	s (Stree			al Route Numb	er. City or To	wn. State. Z	io Code)	
	D = 7 = 9	Idella Albright		r						n, PA			,,	
re,	-155	20a. Method of Disposition	- House	20b.	Place of Dispo	osition (Na	me of		numai	Data	15545 20c. Location	on - City or T	own, Stat	a
Baltimore,	permit. Pages Department of Important: If it any injury or o	1 Burial 2 Cremation 4 Donation 5 Other (S		n Stata					er 2	0, 1999	Hyndm	an, P	ennsy	/lvania
a	Separation of the separation o	21. Signature of Funeral Service	Licensee	158				ess of Facili	*					
ш	20239	/Lasnee 1	12.	2	Ha	arvey	н.	Zeigl	er Ft	meral	Home			
		23a. Part1. Enter the disease, or shock, or heart feilufa. List	complications that	caused the dea	ath. Do not en	ter the mo	de of dy	ing, such as	cardiac	or raspiratory a	rrast,	1	Approx	Imate Between
	Physician	or to the transfer to the tran	only one occood of	audori mia.								1	Onsat	and Death
	/Medical	Immediate Causa (Final disease or condition	Asni	ration	nneumoi	nia							1 107	eek
	Examiner	resulting in death)	a. Aspi		(or as a conse):					1	T W	CCN
	D # C		Cere	bral Va	scular	Acci	dent					-	7-10	days
ć	attending physician and for use as the bunk-transit for use as the bunk-transit clar/Medical Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury												
68760,	s be	Cause (Disease or injury that initiated events	C	Due to (or as a consec	quence of):						-		
x 68	ortificate being physicial as the but	resulting in death) Last Due to (or as a consequence of):												
Bo	at the death ce dby the attendi letached for us.		0									1		
0	a death the atter hed for u	Part II. Other significant condition	ons contributing to	death but not re	sulting in the u	inderlying	cause gi	ven in Part	l.	23b. Dld	tobacco use	contribute	to the car	use of death?
о.	= 00	Diabetes Mell:	itus							10	Yes 2 N	o 3 Pro	obably	4 Unknown
Records,	een signe hould be d									24a. Was	an autopsy	24b. V	Vara auto	psy findings
000										perfe	rmed?	0	vailable p ompletion f deeth?	
Re	The law site has bege 2 s									40	Yes 20KN			a∏ No
œ.	The state of the s	25. Was case referred to medica	1					00.51	15 1			3 1	☐ Yes	2L) NO
of Vital	Physician: this cartific ral director,	examiner?	Hospital:	Inpatient 2] ER/Outpatier	~ 2\lambda	OA OI	hor		n <i>(Check only i</i> me 5 □ Resi		Other /Cone	26.1	
ō	r this caral direction To	27. Manner of Death		of Injury nth, Day Year)	28b. Tima o		28c. Inju		-	28d. Describe		-	ay)	
0	After a fun	1 Natural 5 Pendir		ntn, Day Year)	Injury	М		onk?]Yes 2□	No					
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	To the Hospital or Attanding Physician: The is within 24 hours after death. To the Funeral Director: Attar this carificate ha completely filled in by the funeral director, page Medical Certification: To Be Com		ng Physician: To the Examiner: On the											ise(s)
	within 2 To the comple	29b. Signature and title of certifie		29	c. Licen	se number			29d. Data si	gned (Month	, Day, Ye	ar)		
		100			29c. License number				29d. Data signed (Month, Day, Year)					
	42	100						D54	4946	December 20 1999				
	, 5	30. Name and address of person					1	٠ لــــ	m ^	11502				
		Dr. Boyd Sprenk 31. Data filed (Month, Day, Year)		TIAL HOS Registrar's Sign		Cumb	perl	and, I	עני 2	1502				
	State Registrar	DEC 2 9		Negistral s Sign		/	•							

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sician	Decedent's Nama (First, Middle, Last) GARVIN STEELE									Month	Day	Yeer		
edical	4-5-10-11-4	W 4 t 414 -41			STEELE			4b. City, Town	_	DECEMB		1999	2:25A.M	
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	Usual Residence of 10a. State	10b. County		1	IOc. City, Town	or Location	_					10	d. Inside City Lim	
Director	MD	AL	LEGANY					ONACON	IING			1 KŽ Yes 2□N		
	10e. Sfreet and Nun		JGLAS AV	VENUE		10f. Zip Code 21539					10g. Citizen of What Country? USA			
by Funeral	11. Marital Status 1 Never Marrie 3 Widowed		ed 1 🔯 Y	Decedent Eve d Forces? 'es 2 No is, Give or Dates: W		 13. Was Decedent of Hispanic Origin? (Specify Yas If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify: 				y Yas or No- can, etc.)	or No- lc.) 14. Rece - American Indien, Black, White, etc. Specify: WHIT			
peq	(0000	15. Decedent'	's Education	to of)	16a.	Decedent's Us	sual Occu	pation	Lundina		16b. Kind of B	usiness/indu	ıstry	
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ŏ	17. Fathar's Nama ((First, Middla, L	Last)					18. Mother's	Name (F	First, Middle,	Maiden Sumer	ne)		
To B	20.00		ANDREV	V STEEL	LE					ELIZ	ABETH T	ODD		
-	19a. Informant's Na	me/Relationsh		WIFE	19b.	b. Meiling Address (Street and Number or Rural Route Nu 96 DOUGLAS AVENUE, LO								
	20a. Method of Disp	oosition Cremation	3 □Removal fr		cemeter	e of Disposition (Name of December of Comments of December of Dece				Date coember 3, 1999	20c. Location	- City or Tow	m, State	
important if hen 27 import	4 ☐ Donation 21. Signature of Full				SUNS	1		ass of Facility	- 1	0, 1999	9 CUMBERLAND, MD			
	Dames		,	,				icKenzie F	unera	l Home	P.A. Lo	naconing	g, MD 2153	
	23a. Part . Enter the shock, or hear	ne disease, or o	complications th	hat caused th							ma at	1	A de mana al langua de m	
			orny one couse	on each line.	ne death. Do n	ot enter the m	ode of dy	ing, such es ca	rdiac or r	espiratory ar	rest,		Approximate Interval Between Onset and Death	
	Immediate Cause (disease or condition resulting In death)	Final		on each line. ronary	Artery ue to (or as a c	y Disea	.se	ing, such es ca	rdiac or r	espiratory ar	rest,		Interval Between	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death Month William December 1799 1008 PM R. SANSOM 20 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Agnes HOSpital Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (fn yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys Min. Months Hours 1X M 2 F 1,1914 214-07-2485 85 Maryland Jan Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2 No Allegany Cumberland Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 14228 Cunningham Dr. SW 21502 12. Was Decedent Ever in U,S. Armed Forces? 1 □XYes 2 □ No If Yes, Give Yeer or Dates: W W I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White II 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Fiber Lab Technician 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stella Holsinger Dewey Sansom 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 44081 Clarkview Circle, Calafornia, MD 20619 Donna Coblentz/Daughter 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☑ Burlat 2 ☐ Cremetion 3 ☐ Removat from Stete Dec 4 ☐ Donation 5 ☐ Other (Specify) Zion Memorial Park 23,1999 Cumberland MD 21 Signature of Funerel Service Licensee 22. Name and Address of Fecility Hafer Chapel of the Hills Mortuary 23a. Pert1. Enter the diserse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 21502 Approximate Intervet Between Onset and Deeth Immediate Ceuse (Finet Cerebral Vascular UNIZNOWN disease or condition resulting in deeth) neumonsa gration Due to (or es e consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes an autopsy performed? 1 Yes 2 No 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

Directo

Funeral

2

Completed

Be

r than "natural", or flama 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or the any Injury or other traumatic svent, the Mantal Exemple.

Baltimore, Maryland 21215-0020

Records, P.O. Box 68760

Division of Vital

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Director:

24 hours a

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Examin physician and s the bunal-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or trijury that initiated events resulting in death) Last Physician/Medical

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Completed

Certification:

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(12W)

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

25. Wes case referred to medicat exeminer?

1 ☐ Yes 2 ☑ No

27. Manner of Death

1 Netural

2 Accident

3 ☐ Suicide

(Check only one)

Hospitei: 1 1 tnpatient 28a. Dete of tnjury (Month, Dey Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury et Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Deeth (Check only one)

6 ☐ Could not be determined 28e. Pteca of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier

5 Pending

DEC 2 2 1999

Investigation

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end ptece, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and menner steted.

900 Caton Ave

1 Tyes 2 □ No

29b. Signeture and title of certifier

29c. License number 135

December

MD 21229

29d. Date signed (Month, Dey, Year)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Beltmore

30. Name and address of person who completed cause of death (tiem 23a) (Type, Print)

Thomas 31. Date filed (Month, Dey, Year)

Agnes 32. Registrer's Signeture

State Registrar

DHMH 16 Rev 6/95

Hospital

Marian Colon Colon Colon

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Annie T. Stewart December 1999 24, 14:15 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Sacred Heart Hospital Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Sociel Security Number 7. Age (in vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 218-12-5078 80 20, 1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Md Allegany Frostburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Honeysuckle Lane Apt. G 10 21532 United States 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Meritel Status 1 Never Married 2 Merried 1 ☐ Yes 2 X No If Yes, Give Yeer or Dates: 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Stewart Lily E. Swach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Earl Stewart / Brother 100 Honeysuckle Lane Apt. G 10 0 Frostburg, MD 21532 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Cumberland Crematory 1 ☐ Burial 2 Cremation 3 ☐ Removel from State Cumberland, MD 12/27/99 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 111 Church St. Boal Funeral Home Westernport, Md 21562 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting In death) 24hours . Se 051 Due to (or as a consequence ot): tractintection utanat Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of) (9 0 0 Due to (or as a consequenca of) 95t1 dd Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? 20 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 5 Pending Investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed Box 68760. for use P.O. Records, Division of Vital

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show edics! Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after death with tent of Heelih and Mertal hygiena.

In: If item 27 is marked other than "natural", or items 23e or item into or other traumate event, the Medical Examine market.

Department of Important: If any Injury or

Physician /Medical

Examiner

Physician/Medical Examiner

Be Completed by

Certification: To

Medical

29a. Certifier (Check only one)

Baltimore, Maryland 21215-0020

Director

Funeral

Be Completed by

the Maryland

physician the buriel or Attending Physician: After this funeral 24 hours after deeth.

Funerel Director: A filled in by Hospital

within 2. To the F To the 5

State Registrar

DUNAL 31. Date filed (Month, Day, Year) **DEC 27**

29b. Signature and title of certifier

GEL

30. Name and address of parson who completed cause of death (Item 23a) (Typa, Print)

32. Registrar's Signature

DHMH 16 Rev 6/95

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year) December 24, 1999

RD NLE CLMBERLAN

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600 TS 3H.

Amended # 2 Allegany Co. 12/28/99

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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out.)	Ls		0	U	0

		1. Decedent's Nama (First, Midd	lle, Last)				2. Data of Dealf	1	3. Tima of Death		
ш	Physician	Isabel H. Sweitzer	•				Month	Day Year	19 0050		
	/Medical	4a Fecility Nama (If not institution		rì	· · · · · · · · · · · · · · · · · · ·	4b. City, Town, or	DECEM Location of Death	BER 26,19	0050 A.M.		
	Examiner			'							
_		Sacred Heart Hosp 5. Social Security Number		ge (In yrs. last birtho	(av) If Under 1 Ya	Cumberian If Under 24 Hrs		Ailegany	halan (Ctata as Familia		
н	Funeral	216-22-5845	1 TM airing		Months Day		(Month, Day,		thplaca (Stata or Foraign buntry)		
	Director	Usual Residence of Decedent		3] Yr			02-Oct-1	8 Mar	yland		
	P	10a. State 10b. County	,	10c. City, Town o	r Location				10d. Inside City Limits		
	Meryl he-f sho trined		egany	Frostburg			1 X Yas 2 □ No				
	ter deeth with the Maryler terms 23a or 28a-f show the mast be notified at Tuneral Director	10e. Street and Number 48 To	am Terrace		10f. Zip Code 21532-			og. Citizen of What Co	untry?		
020	by B	11. Marital Stalus 1 Never Married 2 Mar 3 0 Widowed 4 Divorced	H Yes Give	? INo	13. Was Decedent o	f Hispanic Origin? (S uban, Maxican, Puar	pecify Yes or No-	14. Race - Ame Black, White Specify: White			
21215-0020	ed within 72 horygiene. or than "nature. t, tr. Bredeel	15. Deceder (Specify only highe	nt's Education est grade completed)	10	ecedent's Usual Occ sive kind of work dor fa. DO NOT use reti	ne during most of wo		6b. Kind of Business/	Industry		
12	within than the	Elementary/Secondary (0-12)	College (1-4or	5+)		190)					
		8	0	noi	nemaker	40 Mathada Nas		Homemaker			
Ĕ	A S D & M	17. Father's Name (First, Middle,	, Last)			18. Mothers Na	ma (First, Middle, M	laiden Sumama)			
yla	marked marked To	William Evans									
Maryland	and end	19a. Informant's Name/Relations	ship (Type, Print)	19b. N	lailing Addrass (Stre	et and Number or Ru	ural Routa Number,	City or Town, Stata, 2	?ip Code)		
	Heelth Heelth Her tr	Sharon N. Ashby	Daughter	60 \	Victoria Lane	Fro	ostbura	Maryland	21532-		
0.0	I the T	20a. Method of Disposition		20b. Place of Di	isposition (Nama of crematory or other p			20c. Location - City or			
E	Pages nent of int: If he iny or o	1 Burial 2 Cremation 4 Donation 5 Other (5			1-Dec-99 F	rostburg, Mar	oyland				
altimore	유민들	21. Signature of Funeral Service			Aemoriai Park 22. Nama and Add		0-066-77	osibolg, Mai	yidild		
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_		Jonn!	(Hurs					rostburg, MD			
		23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that cause t only one cause on each	od the death. Do not lina.	enter the mode of d	lying, such as cardia	c or respiratory arra	st,	Approximata Intarval Batween		
	Physician	400 00000000000000000000000000000000000		Onset and Death							
	/Medical	Immediala Cause (Final disease or condition	a	rute Con	legat	10	2 days				
н	Examiner	resulting in death)	a	Due to (or as a cor	sequence of):		, 000,000				
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	eeth certificate be executed stending physician end for use as the buriel-transit clary/Medical Examiner	Sequentially list conditions	б.	Due to (or as e con	110	- mare	2007 000		a suff		
o	be exerciclen or burdel-tr	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying	C	Andre and	0	1			2 day o		
16	ficete be physicia s the burn	that initiated events	С	Due to (or as a den	- J W	m DISC	7		15		
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Records,	been sign should be leted by	5 . A	7.14			•	24a. Was an		Wara autopsy findings availabla prior to		
8	w requ	foiline.	Drab 1	b. a	efre 55	ron	perform		completion of cause of death?		
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Vital	Physicien: this certific ral director. TO Be (25. Was case referred to medica examiner?	Hospital:		10		ath (Check only one	ı)			
to	T T	1 Yes 2√No	1 Li/Inpat		HIGH SLI DON		1	nce 6 Other (Spe	cify)		
Division	After fune	27. Manner of Death 1 DNatural 5 Pendir 2 Accident investi	28a. Data of Inj (Month, Da igation	ay Year) 28b. Tim Inju	ry V	juryat /ork? □Yas 2□No	28d. Describe hor	w injury occurred			
8	after death Shrector: Jin by the	3 Suicide 6 Could	not be 28e. Place of In	njury - At homa, farm.	, street, factory, offic	28	28f. Location (Str	reet and Number or Ru	ural Routa Number.		
É	Sher Sher	4 Homicide	building, e	tc. (Specify)			City or Town,	Stata)			
	Hospital 24 hours Funeral stely filled dical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.									
			Examiner: On the basis of and manner s	of axamination and/o							
	within: To the comple	29b. Signature and title of certifie	×C1 D		29c. Lice	nse number	29	d. Data signed (Mont	h, Day, Year)		
	- > - 0		\ 1			A	10				

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DECEMBER 26 · 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S. L. Sandhir, M.D., 48 Tarn Terrace, Frostburg, Maryland 21532

State Registrar

Division of Vital Records, P.O. I

31. Data filed (Month, Day, Year) DEC 2 8 1999

32. Registrar's Signatura

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30-Dec-99 Frostburg Maryland

Durst Funeral Home, 57 Text Asse, Fred Line Activities

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DEC 28 939 James & Sporter

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 4 1690

_	Decedent's Name (First, Middle, La.	od)	Certifica	ite of Dea		Re 2. Data of Deat	eg. No.		3. Time of Death	
Physician	штгтлм АМ	OUS	S	EATON		Month DECEME	Day	Year		
/Medica Examine	to English Name (Mant Institution of			4b. City	y, Town, or Loc	ation of Death	4c. County	of Death	10.1001	
Funeral Director	5. Social Security Number 6. S 219–16–0324	7. Age (In yrs. I	last birthday) If Und Month		ndar 24 Hrs. urs Min.	B. Date of Birth May 23,	1923	Country	ca (Stata or Foreign	
the Maryland 28a-f show notified at	Usual Residence of Decedant 10a. Stata 10b. County Maryland Charles		y, Town or Location La Plata				10d. Inside City Limits 1 ■ Yes 2 □ No			
6 9 9	12265 Manor Court		101. 2	ip Code 20646			og. Citizen of V United			
- p #8	3 ☐ Widowed 4 ■ Divorced	12. Was Decedent Ever In U, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: WWII		edent of Hispania ecify Cuban, Me: 2 No Spe		ify Yes or No- ican, etc.)		nace - American Indian, Black, White, etc. city: White		
Maryland 21215-0020 82 about be find within 72 hours at 21 about be find within 72 hours at 31 and Merital byglerie. The marked other than "caltural", or traumatic event, the Medical Exam	15. Decedent's Ec (Specify only highest gra Elementary/Secondery (0-12)	lucation de completed) College (1-4or 5+)	(Give kind of a life. DO NOT	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Plumber				usiness/indus	stry	
yland ;	17. Father's Name (First, Middle, Last)				Mother's Name Edith Ma	First, Middle, Maske	faiden Sumam	(8)		
2 2 24 6	19a. Informant's Name/Relationship (Kathy McClary, Dat		19b. Mailing Address 12265 Mar							
Baltimore, nomit. Papes 1 a Department of Hea Important: If Item my Injury or othe 8068.	20a. Method of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Other (Specific	Removal from State	rles Memor	other place)	dens 12		20c. Location - Leonarc		•	
Balti permit. Departm Imports any inja	21. Signature of Fune all Service Licentifications of Fune all Services Licentifications of Fune all Service	field, Jr., MOO	22. Name 052 22955	and Address of F	Bring acility Bring	sfield l	Funeral dtown,	Home MD 20	, P.A. 650-0279	
Physician /Medical Examiner	23a. Part1. Enter the disease, or com shock, or heart feilure. List only Immediate Cause (Final disease or condition resulting in death)	CAR	DION	lyop			st,	ny Ny	oproximate interval Between onset and Death 10 RE THRN L Y2007 -	
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E 08		d								
P.O.				ig in the underlying cause given in Part 1.				23b. Did tobacco usa contributa to the cause of d		
ecords aw requires as been sign 2 should be						24a. Was ar perform	n eutopsy ned?	availe	a autopsy findings able prior to pletion of causa ath?	
Vital Riclen: The liclen: The liclen: The lice rector, page	25. Was case rafarred to medical			26. F	Placa of Death	1 ☐ Ye		101	Yes 2□ No	
H Sh	1 ☐ Yes 2 No	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	28c. Injury at Work?	21	e 5 Reside				
Oivision or Attendate deat Director: in by the	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined		M ome, farm, street, fact /)	1 Yes		31. Location (Str. City or Town		er or Rural F	Routa Number,	
Hospi 4 hou Funer tely fill	29a. Certifier (Check only one) Certifying Physics Certifying Ph	ysician: To the best of my know wher: On the basis of axaminat end menner steted.								
To the vithin 2 To the comple	29b. Signature and title of certifier	and h	<u> </u>	9c. License numl		29	9d. Date signed	d (Month, Da		
6	30. Name and address of person who design and address of person who design are supported by the support of the			751						
State	31. Data filed (Month, Day, Year) DFC 1 3 19	32. Registrar's Signal		bar.						

The state of the state of

Amended # 30 MLU Allegony Co 12/28/99

Directo

Funeral

p

Completed

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Months

10f. Zip Code

state of Maryland / Department of Health and	Mental Hygiene	00 1	100
Certificate of Death	Reg. No.	4 44	1169
	2. Date of Deeth Month Day	Year	3. Time of De

Cumberland

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

Physician
/Medical
Examiner

Opal Lura Simpson

1. Decedent's Neme (First, Middle, Last)

4a Fecility Name (If not institution, give street and number)

1□M 2 F

Devlin Manor Nursing Home

December 4b. City, Town, or Location of Death

14-Dec-08

11:52AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 N Yes 2 No

Funeral Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health end Menial Hygiene. Important: If item 27 is merked other than "naturel", or iter any injury or other traumatic event, the Medical Examina. 0068.

Physician /Medical

Examiner

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After

i or Attending efter death. Director: Aft

To the Hospital c within 24 hours of To the Funeral Di

completely

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certificate be

P.O.

Division of Vital Records,

Examiner

Physician/Medical

by

Completed

Be

2

Certification:

Medical

altimore, Maryland 21215-0020

with the Meryland

death

5. Social Security Number 216-22-6639

11. Marital Status

Usual Residence of Decedent 10a. Stete 10b. County Maryland Allegany 10e. Street and Number 1403 Bedford Street

10c. City. Town or Location Cumberland

7. Age (In yrs. last birthday)

Yrs.

21502-Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.)

U.S.A.

14. Race - American Indien,

Maryland 21502-

1999

Virginia

4c. County of Death Allegany

3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12)

1 Never Married 2 Married

College (1-4or 5+)

Daughter

1 Yes 2 No If Yes, Give Year or Dates:

12. Was Decedent Ever in U,S. Armed Forces?

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) School Teacher

22. Name and Address of Facility

1 ☐ Yes 2 ☐ No Specify:

16b. Kind of Business/Industry

Specify: White

10g. Citizen of What Country?

17. Father's Name (First, Middle, Last)

18. Mother's Name (First, Middle, Maiden Sumame) Margaret Rachel Ramsey

Cumberland

George Washington Ryder

19a. Informent's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Nancy Simpson 20a Method of Disposition

1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

1403 Bedford Street 20b. Place of Disposition (Neme of cemetery, crematory or other place) Dawson Cemetery

Date 20c. Location - City or Town, Stete 27-Dec-99 Rawlings, Maryland

Education

21. Signature of Funeral Service Licenses

Ru 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiac or respiretory arrest, nock, or heart feilure. List only one ceuse on each line.

Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Immediate Cause (Final disease or condition resulting in death)

Approximate Interval Between Onset and Death

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of)

Due to (or as e consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying course given in Part I.

I call Comen 1980

23b. Did tobacco use contributs to the cause of death? 1 Yes 2-No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings aveilable prior to completion of cause of death?

1 Yes 2 →No

1 ☐ Yes 2 ☐ No

25. Was cese referred to medical exeminer? 1 Yes 2 No

27. Manner of Death

1-BNaturel

29a. Certifier

2 Accident

(Check only one)

Hospital: 5 Pending Investigation

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

Other: 4₽ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how Injury occurred

26. Place of Death (Check only one)

28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 1 Yes 2 No

6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28f. Location (Street end Number or Rural Route Number, City or Town, State) 1 Cartifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) end menner stated.

29b. Signature end title of certifier

29c. License number 1217565 29d. Date signed (Month, Dey, Year) De. 23, 1889

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

An thory J Ballinu Ph D 912 Not 1 Hay Lover, 1 1 1502

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signeture

DFC 2 8 1999

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Legistre Control Street

seriotype West unigation Ryden

Murparet Rochel Knimsy

STATE OF THE OWNER, THE PROPERTY OF THE PROPER

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** Dora Lee C. Sharon December 27, 1999 10:52 am /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland Allegany 8. Date of Birth (Month, Day, Year)
Aug 23, 1926 9. Birthplaca (State or Foreign Country)
6 MD If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 F Months 215-34-2680 73 Director Usual Residence of Decedent the Maryland 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐Yes 2 ☐ No Director MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 21502 USA 1504A East Oldtown Road natural", or lisma 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Merital Stetus Black, White, etc. filed within 72 hours after. Hygiene. Oher than "natural", or its 1 ☐ Yes 2 ☐ **K**o If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify Specify: white ğ 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) private sitter sitting Pages 1 and 2 should be filed in nert of Health and Mantal Hygis int: If Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Claude Westfall Ruth (Brown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Katheryn E. Hill Important: If Item 27 h any injury or other tre 2059. 1500G Old Towne Mano; Cumberland MD 21502 20a. Melino or Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Laurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Memorial Parl2/31 Cumberland, MD 21. Signature of Funeral Service Licenses 22 Scarperii Faruneral Home P.A. Cumberland, Maryland 23a. Part1. Enter the disease, or compilations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 20 minutes Examiner Examiner attending physician end for use as the bunal-transit The lew requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical Due to (or as a consequence of) 88 215-34-2680 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 700 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death? 1 Yes 2 □ No certificata Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Dora Sharon Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Naturel 5 Pending investigation 1 □ Yes 2 □ No deeth 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by 4 | Homicide **Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and titla 29c. License number 29d. Date signed (Month, Day, Year) of certifier O. December 27, D0054426 c 3 e of de ath (Item 23a) (Type, Print) 30. Name and address of person who comp 10 Dr. Michael D. Zan Memorial Hospital Med. Bldg. 105,500 Memorial Ave. Cumberland 31. Date filed (Month Pay Year) 32. Registrar's Signature State 1999 Registrar

Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legibie.

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day 1999 DECEMBER 8:40PM Nancy Elizabeth Thompson 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign Country) Days 1 ☐ M 2 🔀 F Vre 060-14-4863 December 13, 1920 New York Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 ☑ No North Carolina Kannapolis 10e. Street and Number 10a. Citizen of Whet Country? 10f. Zip Code U.S.A. 14. Race - American Indien, Black, White, etc. 1621 Morningside Court 28081 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 ₩idowed 4 Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry . Elementary/Secondary (0-12) College (1-4or 5+) 1 Year Registered Nurse Hospital 17. Fether's Name (First, Middle, Lest) 18. Mother's Neme (First, Middle, Malden Sumame) Edward Rapp Catherine Teahan 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Bruce W. Thompson (son) 1621 Morningside Ct., Kannapplis, NC 28081 20b. Place of Disposition (Neme of cometery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Maplewood Cerretery 22. Name and Address of Fecility 12/23/99 Wilson, North Carolina Mattingley-Gardiner Funeral Home, P.A. Javelner Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respirelory errest, Maryland 20650 approximete or heart failure. List only one ceuse on eech line. Month Immediate Cause (Finel diseese or condition resulting in death) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause givery Part I. 23b. Did tobacco usa contribute to the cause of death? 3 Probably 4 Onknown 1 Yas 2 No 24b. Were autopsy tindings aveileble prior to completion of cause of feath? 24s. Was an autopsy performed? 1□ Yes 2210 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[] No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Mature! 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

be detached for use es this certificate

The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

or Attanding Physician:

After

death.

ofter death Director:

within 24 hours e To the Funeral L Hospital

Physician

/Medicai

Examiner

10a. Stete

Director

Funeral

þ

Be Completed

Funeral

Director

the Maryland

Peges 1 end 2 should be filed within 72 hours after deeth with the Marylar nent of Haafith end Mental Hygiena. Mit. If them 27 is marked other than "natural; or items 23a or 28a-f show mit. If them 27 is marked other than "natural; or other traumatic event, its Medical Examiner must be notlined any on other traumatic event, its Medical Examiner must be notlined.

Department of Important: If any injury or

Physician

Examiner

/Medical

Physician/Medical Examiner the buriel-transit þ Completed funeral director. Be Medical Certification: To the filled in by

25. Wes case referred to medi 1 Yes 27. Manner of Death

29a. Certifier (Check only one)

29b. Signature and title of

xamfner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Morgh, Day, Year)

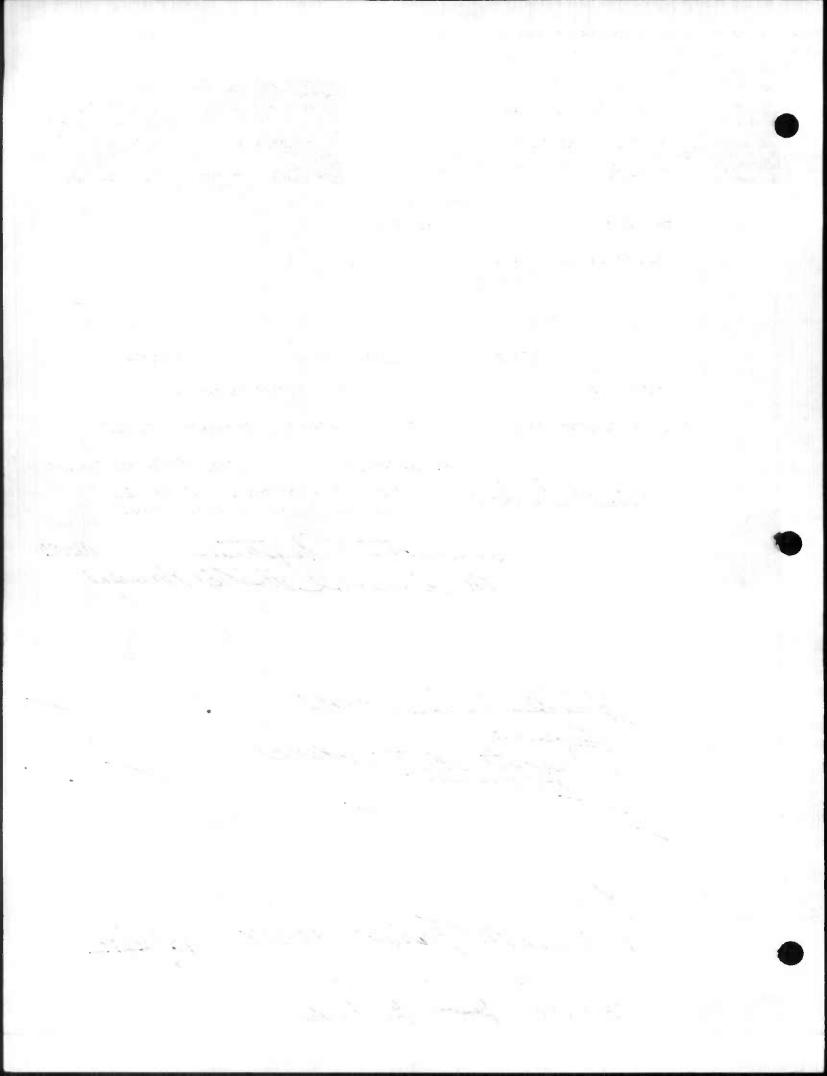
30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) DR. DAVID M. FEDERLE HOLLYWOOD, MD.

State Registrar

31. Date filed (Month, Day, Year) DEC 23 1999 32. Registrar's Signature

20636

1 Certifying Phyafcian: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end manner es stated.



1. Decedent's Name (First, Middle, Last)

AMEND ITEMS: #23 PART I, II, 27 PER Certificate of Death Reg. No.

9. Birthplace (State or Foreign Country) Maryland

10d. Inside City Limits XX Yes 2 □ No

3. Time of Death

06:05 AM.

2. Date of Death

	Physician /Medical	Ronald	William	Todd					Decem	per 18	1999	06:05 4	
	Examiner	4e Facility Neme (If not institution, git				1			ation of Dea				
	-		Commerce S	Street e (In yrs. last birt	thday) If Und	er 1 Year		rlock			ches	ster oplace (State or Fo	
	Funeral Director		VITT				Hours	Min.	B. Date of Bi (Month, Di an 26	,1940	Mar	yland	
	Du Au	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside Ci			10d. Inside City Li	
	Mary	Maryland Dorches	ster	Hur1	ock							XX Yes 2□	
	th with the Maryla 23e or 28e-f show at be notified at al Director	10e. Street and Number 305 Commerce Str	reet	1	10f. Z	ip Code	1643			_	Citizen of What Country?		
020	our after death val., or them 23a Examiner must by Funeral	11. Marital Status 1 □ Never Merried ※ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Armed Forces? 1 Xes 2 1 If Yes, Give Year or Dates:	(es 2 □ No s. Give			gin? (Spec i, Puerto Ri		14. Race - American Indian, Black, White, etc. Specify: White				
5-0	and 2 should be filed within 72 hours at and 2 should be filed within 72 hours at and 27 is marked other than "natural", or ar traumatic event, the Medical Example To Be Completed by F	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Decedent's Usual Occu			ation during most	of working	7	16b. Kind of B			
2121		Elementary/Secondary (0-12)	College (1-4or 5	(Give kind of work done during most of working life. DO NOT use retired) Fork Lift Operator						Farm Ed Manufa			
yland		17. Father's Name (First, Middle, Last Willie T. Todd	"					Ada R		, Maiden Sumar	ne)		
		19a. Informent's Name/Relationship	(Type, Print) Wife	19b. Meiling Address (Street and Number or Rural I 305 Commerce Street Hu					urlock, Maryland 21643				
Baltimore,	Pages 1 nant of He ent: If hen ary or oth	20a. Method of Disposition 1 \overline{\mathbb{N}} \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \								20c. Location		rown, State Maryland	
Balt	Departr Departr Imports any Inju	21. Signature Funeral Service Lice	21. Signature Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 2161:										
	Physician	23a. Pert Enter the disease, or comshoot, or heert feilure. List only	plications that caused one cause on each li	the death. Do r						· ·	yran	Approximata Interval Between Onset and Deatl	
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a	ATHEROSCLEROTIC CARDIOVAS						R DISE	ASE		
	P z		Due to (or as a consequence of):										
oʻ	be executed ician and burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or as a consequence of):							1	-161	
	death certificate be executed to attending physician and ed for use as the burial-transit sician/Medical Examir	Cause (Disease or injury that initiated events resulting in death) Last	C	Due to (or as a c	onsequence of):							
30X	th cer tendir or use		d										
6	0 0 0	Part II. Other algnificant conditions of	contributing to death be	ut not resulting in	the underlying	ceuse give	en in Part I		23b. Did	tobacco use co	ntribute	to the cause of de	
, P.O	as that the igned by the be detach by Phys	EMPHYSEMA							1 🗆	Yes 2□ No	3.20 Pr	obably 4 Unk	
	requir seen s hould	CHRONIC ALCOHOL	LISM						24a. Was peri	s an autopsy ormed?	(Were autopsy finding a vailable prior to completion of cause of death?	
Re	s certificate has to director, page 2 s o Be Compli								1,20	Yes 2□No		Yes 2□ No	
=	ysician: The last certificate had director, page	25. Wes case referred to medical examiner?					26. Place	of Death	Check only	one)	1		
of	Physician: this certific ral director, TO Be	1 X Yes 2 No 27. Manner of Deeth		ent 2 ER/Out			411110	-		idence 6 DDt		ily) Scene	
	l or Attending Physister death. Director: After this of alin by the funeral direction.	1 Naturel 5 Pending 2 Accident investigatio 3 Suicide 6 Could not be			ime of njury M		yat k? Yes 2 ☐	No		how injury occur			
Divi	or Aft after d Direct J in by	4 Homicide determined	200. Place of inju	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28	28f. Location (Street and Number or Rural Route Number, City or Town, State)				

To the Mospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detended. Phy Be Completed by Medical Certification: To

use contribute to the cause of death? 1 Yes 2 No 3.2 Probably 4 ☐ Unknown **EMPHYSEMA** 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? CHRONIC ALCOHOLISM 1 Yes 2 No 1. Yes 2□ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Scene 1 Yes 2 No 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Naturel 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar Stephen S.
31. Date filed (Month, Day, Year) -adent2 29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

December 18, 1999

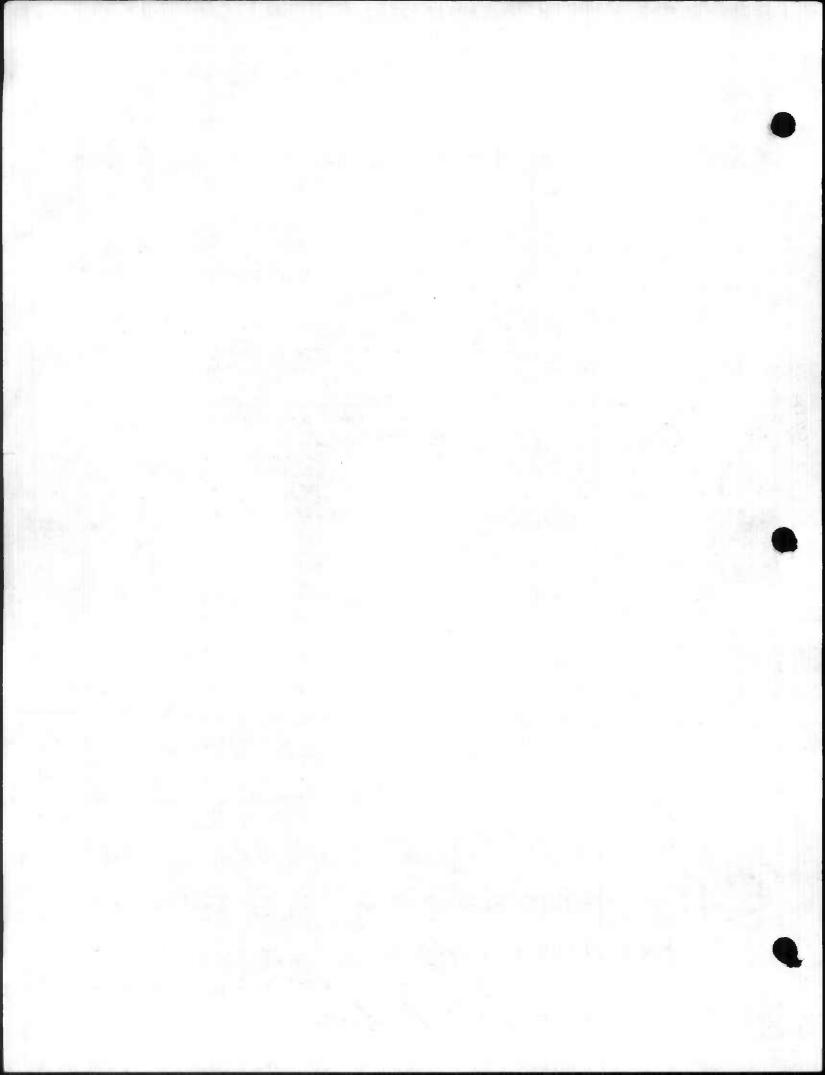
30. Name and eddress of person who completed cause of death (trematal) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

DEC 21 1999

29b. Signature and title of certifier

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Ann Carmel Vassallo 25 1999 Dec 5:50PM 4e. Facility Neme (If not institution, give street end number, 4b. City, Town, or Location of Deeth 4c. County of Death 141 W 3rd Street Cumberland If Under 24 Hrs. 8. Date Hours Min. (Mon Allegany If Under 1 Year 8. Date of Birth (Month, Day Yeer) 1925 Birthplace (State or Foreign County) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex Months Days 1 M 2 TF 74 213-22-2640 Yrs. Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 141 West 3rd Street USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 ☐ ¥60 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1□Yes 2□No Specify: white 3 ☐ Widowed 4 ☐ Divorcad 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) homemaker own home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Thomas Vassallo Anna (Rosingana) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Clifford T. Vassallo 225 Boyd Avenue; Winchester VA 22601 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriai 2X Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Scarpelli Funeral Home12/26 Cresaptown, MD 21. Signature of Funeral Servica Licanses 22 Scarperii Farineral Home P.A. Cumberland, Maryland ames + 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final . Arteriosclerotic heart disease disease or condition resulting in death) uk yrs Due to (or as e consequença of): Due to (or as a consequence of) Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Unknown 1 Yes 2 No 3 Probably 24a. Wes an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? No 1 🗆 Yes 1 ☐ Yes 2 ☐ No

Physician /Medicai Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

MD

tem 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Med cal Examinar must be notified at

the Marylend

death

filed within 72 hours efter

permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If fem 27 is marked other than any injury or other traumatic event

Baltimore, Maryland 21215-0020

Box 68760

Records, P.O.

Division of Vital

physician and the burief-transit The law requires that the death certificate be executed ettending USB ŏ the signed by t peeu After this certificate has funerel director, page 2 To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

Physician/Medical þ Completed Be ٩

3 4

State

Registra

Examiner Certification: Medical

Sequentially list conditions, if eny, leading to Immediete cause. Enter Underlying Cause (Disease or injury that Initiated events resulting In death) Lasf Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Yes 2□ No Other: 4 \sum Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homleide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b, Signature and title of cegifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) DEC 2 8 1999

Paul

Snow, M.D. 32. Registrar's Signature

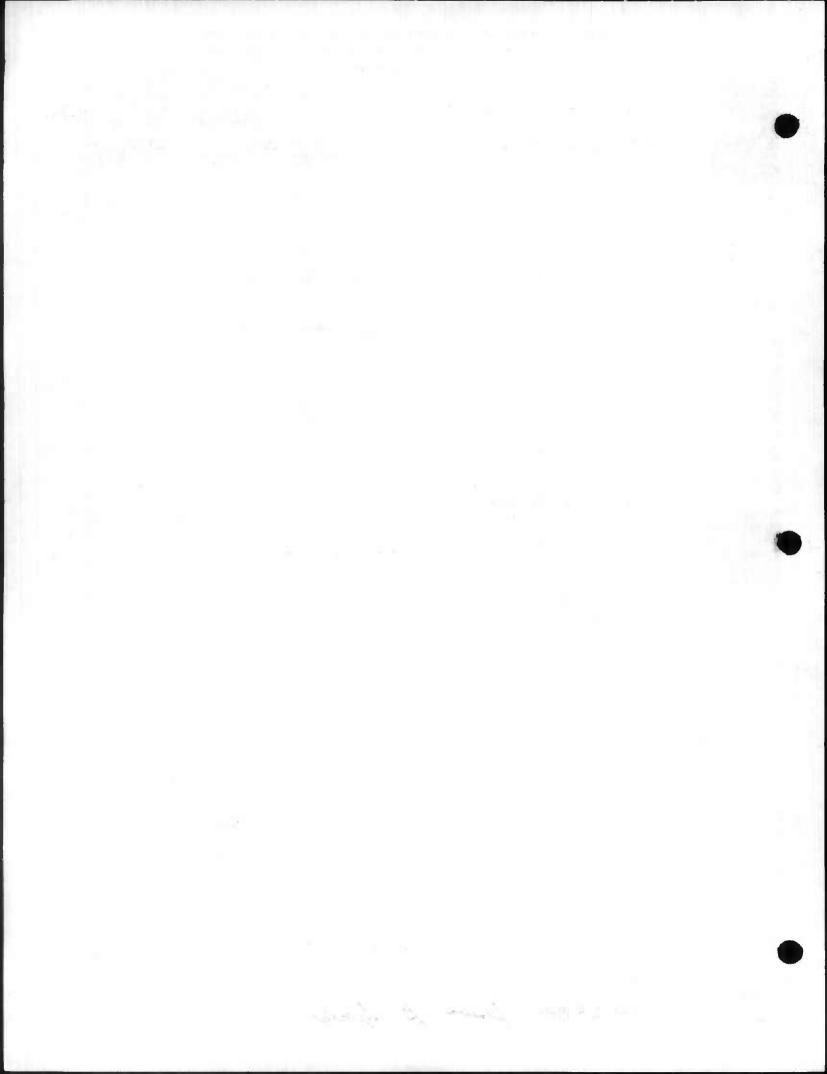
ress of person who completed cause of death (Item 23e) (Type, Print)

D 09157

124 W 3rd St Cumberland Md 21502

Dec 25 1999

Dpty Med Ex



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month WALBERT 12 4e. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth CARE CENTER EXINGTON PARK, MD MARY'S If Under 24 Hrs. Hours Min. If Under 1 Year Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthday) 8. Dete of Birth (Monthy Dey, 1 M 2 F Months Days 214-58-0321 Usuel Residence of Decedent 50 Yrs. MARYLAND 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 5+ LEXINSTON mARY'S 10f. Zip Code 10g. Citizen of Whet Country? 21412 GREAT 20653 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Raca - American Indien, Bieck, White, etc. Never Merried 2 Married Yes 2 No f Yes, Give Yeer or Detes: 1□Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorcad White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Unknown Unknown 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Unknown 19a. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Thomas Wilson / Friend 42391 Riverwoods Dr., Leonardtown, MD 20650 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ■ Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Gardens 12/16/99 Leonardtown, Maryland 21. Signature of Funerel Service Ligan 22. Name end Address of Fecility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonrdtown, MD 20650-0279 Ronald L. Thompson .M01154 23a. Pent1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest acco use contribute to the cause of death? 3 Probably 4 Unknown eutopsy 24b. Were eutopsy findings evellable prior to completion of cause of deeth? ce 8 Other (Specify) v Injury occurred eet and Number or Rural Route Number, Stete) se(s) end menner as steted. e end pleca, end due to the cause(s)

23415 Three Notch Road, California, Maryland 20619

C 0 Division of Vital Records. **Physician**

/Medical

Examiner

Directo

Funeral

by

Completed

Be 2

Funeral

Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. Imprortant: If Item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinet must be not an ence.

Baltimore, Maryland 21215-0020

LINDA

BAYSIDE

5. Social Security Number

10e. Street end Number

Unknown

20e. Method of Disposition

UNknown

10e State

cian dical	Immediate Cause (Final disease or condition		x Pul	MI MA d do	Embolus	Intervel B Onset an
Examiner and	resulting in deeth) Sequentielly list conditions,	Due to	or es e consequenca	of):)	
es the bur	Sequentieily list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting In deeth) Lest	C. Due to (or es e consequence	of):		
tte has been signed by the ettending physicit page 2 should be deteched for use as the bu completed by Physician/Medical	Part It. Other significant conditions co	entributing to death but not re	sulting In the underlying	ng cause given in Pert I.	23b. Did tobacco use of	contribute to the cause 3 Probably 4
N Q					24a. Wes en eutopsy performed?	24b. Were eutops evellable prio completion of deeth?
Be C	25. Wes case referred to medical			26 Place of D	Deeth (Check only one)	6
To B	exeminer?	Hospitel: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐	Other	Home 5 Residence 8 0	Other (Specify)
e funeral	27. Manner of Deeth 1 Dearurel 5 Pending 2 Accident investigation	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injurat Wd 17 1 Yes 2 No	28d. Describe how Injury occ	
completely filled in by the funeral director, page Medical Certification: To Be Com	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pleca of Injury - Ath building, etc. (Speci	nome, farm, street, fed	tory, offica	28f. Location (Street and Nur City or Town, Stete)	mber or Rural Route Nu
pletely fille	29e. Certifier (Check only one) 1 Certifying Physics Medical Example	elclan: To the best of my kniner: On the besis of exeminer end manner steted.	owiedge, deeth occurretion end/or investige	ed et the time, dete end ple ion, in my opinion, deeth oc	ce, end due to the ceuse(s) end recurred et the time, dete end plece	menner as steted. a, end due to the cause
We	29b. Signeture end title of cartifier	1		29c. License number D19917		ned (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

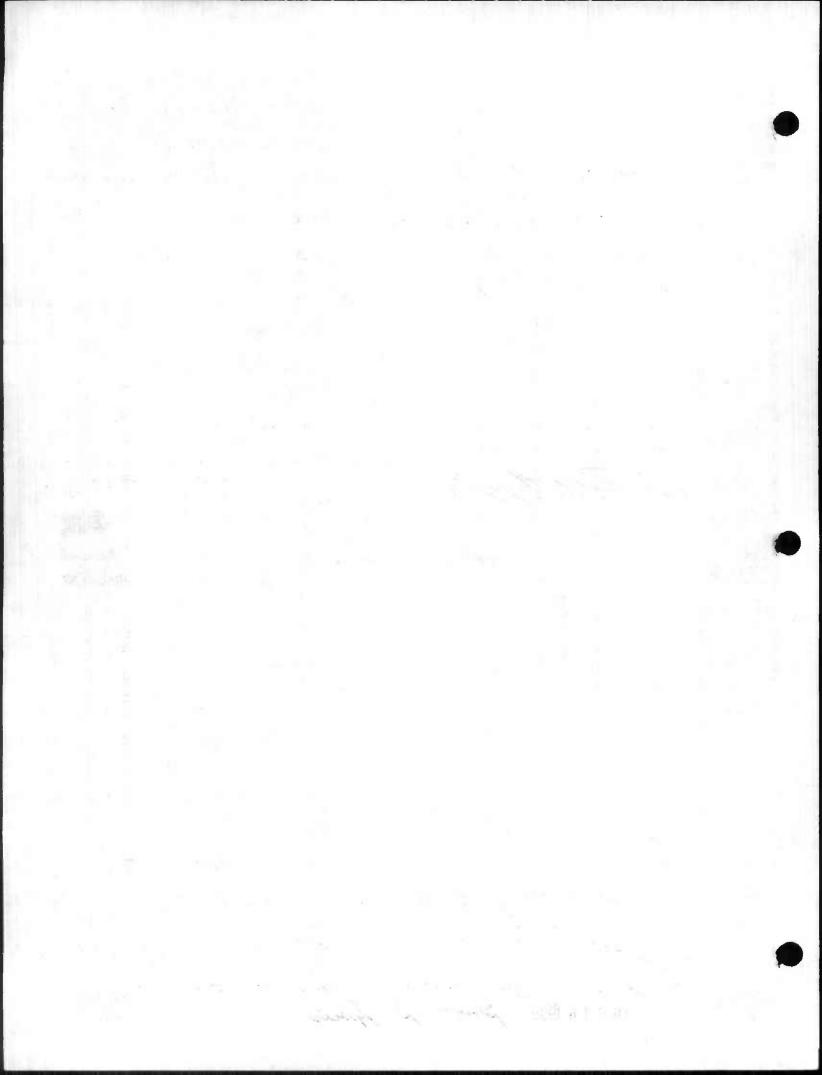
Boyd, M.D.,

DEC 1 6 1999

State Registrar

James C

31. Dete filed (Month, Dey, Yeer)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99

41697

		Ce	rtificate of	Death	Re	g. No.		
Physician /Medical		ILSON		4	Dete of Death Month	21 X	3. Tima of Death 15:35 P	
Examiner	4a Facility Name (If not institution, give street and number) WAS H. CO. HOS I 5. Social Security Number 6. Sex 7. Ag	e (in yrs. last birthday)	If Under 1 Year	4b. City, Town, or Local HAGERS TO	Mer		Death INGTON Birthplece (State or Foreign	
Funeral Director	213-22-3138 VXM 2□ F Usuel Residence of Decedent	59 Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, 1 UGUST 3(Country) IARYLAND	
death with the Manyland me 23e or 28e-f ahow rmant be notified at	MARYLAND ALLEGANY	10c. City, Town or Lo	STONE		10d. fnside City Limits 1□Yes �∏No			
uth with the 23s or 2 unit be no	10e. Street and Number TOWN CREEK ROAD		10f. Zip Code 215	30	10	10g. Citizen of What Country? U.S.A.		
burs after death v al., or frame 23a Example: must	11. Marital Status 12. Was Decedent Armed Forces? 13. Widowed 4. Divorced 12. Was Decedent Armed Forces? 1 Yes, Give Year or Dates:	No	Wes Decedent of I If Yes, specify Cub	dispanic Origin? (Spec an, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	Yes or No- n, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE		
filed within 72 hours after Wydens. Whysiens. Whysiens. Completed by Full	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Q College (1-4or 5	(Give	dent's Usual Occup kind of work done DO NOT use retire LY FARM	during most of working	7	6b. Kind of Busin		
Saga W	17. Father's Name (First, Middle, Last) SHERMAN MARTIN WILSON			18. Mother's Name (
DEL			AVIDSON	STREET FROS	STBURG,	MARYLAN	D 21532	
Pages nent of ant: If It ary or o	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	SUNSET CI	matory or other pla EMETERY D	EC 24 1999			ty or Town, Stete D MARYLAND	
pemit. Departr Importa any Inji	23a. Pert1. Enter the disease, or complications that caused shock, or heart feilure. List only one cause on each fi	MI 40	04 DECATU	AMS FUNERA IR STREET C	UMBERLA	ND MARY	LAND	
Physician /Medical Examiner poerus perinasis	b	TRICULAR Due to (or as a consec	quence of):	LLATION			1 9 AY	
ding physicia se as the bur	Cause (Disease or injury that initieled events resulting in death) Last Due to (or es a consequence of):							
	Pert II. Other algnificant conditions contributing to death be	ut not resulting in the u	nderlying cause gi	ven in Part t.	23b. Did tobecco use contributs to the cause of death			
by by					24a. Wes an perform	autopsy	Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause	
The lay ate has page 2					1 ☐ Yes	2 No	of deeth? 1 ☐ Yes 2 ② No	
nding Physician: Thi th.: After this certificate of funeral director, pag- stion: To Be Co	25. Was case referred to medical examiner? 1 Yes 20 No Hospital: 1 Inputie 27. Manner of Death 1. Natural 5 Pending investigation	v 28b. Time o	28c. Inju		n (Check only one) me 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			
To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injurishing, etc				City or Town,	Stete)	or Rurel Route Number,	
the Hospi in 24 hou the Funer spletaly fill	29a. Certifier (Check only one) 1 Certifying Physician: To the best of Examiner: On the basis of and manner sta	examination and/or in	vestigation, in my	opinion, death occurred	d at the time, dal	le and place, and	d dua to the cause(s)	
To the within to the complex New Mee	296. Signatura and tale of contifier Ciscuit	teal, and	29c. Licens	0 4 6 6	29	d. Date signed (I	Month, Dey, Year)	
~2/3	JOEZ L. ROSENTHAL, A	eath (Item 23a) (Type,	Print) 22 E. A	WHETAMS	T HA	CALSTOW	WMD 21740	
State	31. Date filed (Month, Day, Year) 32. Áegistra	ar's Signature						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

_					State of N	iaiyiai		tificate o			nemai i i	Reg. No.	9	41698		
ı	Physic	ian	Decedant's Neme (First,	Middle, Las		337:33	:				2. Dete of D	ember 25, 1	Odor Odor	3. Time of Death 6:20 p.m.		
d	/Medi	cal	4e. Facility Name (If not ins	stitution aive	Bessie Mat		iamson		4b. City.	Town, or Le	Dece			6:20 p.iii.		
1	Exami	ner	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		e Nursing H				Lonac			40. 000110		egany		
	Funeral Director		5. Social Security Number 220-52-9418	6. Se	-		lest birthday) Yrs.	If Undar 1 Ye Months De		dar 24 Hrs.	8. Dete of Bi	rth ay, Yeer) ar 02, 1902		lece (Stete or Foreign try) MD		
	ylend		Usual Residence of Deced 10a. State 10b. 0	ent County		10c. Cit	y, Town or Lo	cation					10	Od. Insida City Limits		
	e Me	ctor	MD	Alle	gany				Lona	coning				1 N Yes 2 No		
	with th	Dire	10e. Street end Number	10 Alla	gam: Straat			10f. Zip Coo		539		10g. Citizen of	Whet Coun			
	be filed within 72 hours after death with the Meryland tal Hygiene. d other than "natural", or items 23a or 28a-f show event, ir a Medical Expriser is an item for inclined.	Funeral Director	11. Maritel Status		gany Street 12. Wes Decadan Armed Forces	?	,S. 13. \	Was Decedant I Yes, specify (ecify Yas or N Rican, etc.)	0- 14. Rad Ble	ce - America ck, White,	an Indien,		
020	ours aft	þ	1 □ Never Married 2 □ 3 □ Widowed 4 □ Div		1 ☐ Yes 2 ☑ If Yas, Giva Year or Detes	•		I□ Yas 2风	No Spec	eify:		Specif	y:	White		
15-0	n 72 hours "natural",	etec	15. De (Specify only	cedent's Edu highest gred	ucation fe completed)		16a. Decedent's Usuel Occupetion (Give kind of work done during most of life. DO NOT use retired)			nost of work	ing	16b. Kind of B	d of Business/Industry			
21215-0020	2 should be filed within 72 h and Mental Hygiene. Is marked other than "natur aumatic event, Ira Medical	Completed	Elementary/Secondery (4	0-12)	College (1-4or	5+)	life. L	OO NOT use re	Home 1	maker			Но	me		
Maryland	should be filed and Mental Hygi marked other imatic event, I	Be	17. Fether's Nema (First, N	fiddle, Last)					18. Mc	other's Nem		, Meiden Sumer				
ryle	2 should and Men is marke sumatic	T _o	10a Informantia Nama/Da	letienskin /T	Unknown		101 11-11-1	- 4-11 (01				Margie Fou				
Ma	D 5 1 5		19e. Informent's Name/Re William T			1	19b. Meilin	_				per, City or Town				
re,	CENL		20a. Method of Disposition			20b. F	20b. Place of Disposition (Name of cemetery, cremetory or other place)				Dete	20c. Location				
imo	Pege nent c int: If ury or		1 🖾 Burial 2 □ Crem 4 □ Donetion 5 □ Ot	,		el Hill Cen			December 28, 1999	Mo	scow N	fills, MD				
Baltimore,	pemit. Peg Department Important: If any Injury o		21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility													
_	00 = 60		Eichhorn-McKenzie Funeral Home P.A. Lonaconing, MD 21: 23e. Pert 1. Enter the disaase, or compilications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete													
	Physician /Medical	3 19	23e. Pert1. Enter the disase shock, or heert feilure	ise, or comp b. List only o	ne ceuse on eech	line.					or respiretory e	errest,		Approximete Intervel Between Onset end Death		
1	Examiner		disaese or condition resulting in deeth)	a. Due to (or as a consequence of):												
	De sit	Examiner			b. C.	honi	L atr	ial fee	brilla)	tion				270915		
'n,	ificete be executed g physician and es the bunel-transit	Ехап	Sequentielly list conditions if eny, leeding to immediate cause. Enter Underlying Ceusa (Disaase or Injury		b. Chronic atrial fibrillation Dua to (or es e consequence of): Aortic S Athero schotic coronary					tenos	i and		10000			
68760,	ysicia ysicia	edicai	Ceusa (Disaase or Injury thet Initieted events resulting in deeth) Lest	*	c	Due to (o	r as a consequ	uence oi):	C0/0,	14/10	alky.	discuse		14 7 6475		
	5 00		resulting in deetily Lesi	L	d								i			
Box	eath certi	clan/			·											
P.O.	that the death cer led by the attendin detached for use	Physician/M	Pert II. Other significant co				ulting In the ur	ndarlying cause	given In Pe	ert i.				the cause of death?		
	res that igned b be deta	by PI	Dia	peter	ne l/itu	5					10	Yes 28 No	3 Prob	ably 4 Unknown		
Vital Records,	requii	Completed							-			s en eutopsy ormed?	con	re autopsy findings illable prior to inpletion of causa eath?		
E E	The ete h page	Соп									1 🗆	Yes 25 No	1 🗆	Yes 2□ No		
Vita	Physician: r this certific rral director,	Be	25. Wes case referred to m exeminer?	-	fospitet:				A		(Check only					
of	Phy this raid	- To	1 ☐ Yes 2 ☐ No 27. Menner of Deeth		1 ☐ Inpat		ER/Outpetien 28b. Time of	3LI DOA				Idence 6 Oth)		
	Attending I r death. ector: After by the funer	tion	1 Naturel 5 ☐ F	ending envestigation	(Month, D	y Year)	injury		njury et Vork? Yes 2		260. Describe	now injury occur	190			
Division	X = = c	Certification:	3 ☐ Suicida 6 ☐ C	Could not be letermined	28e. Pleca oi In building, e	jury - At ho tc. (Specify	ome, lerm, stra y)	nat, lactory, offi	Се		28f. Location (City or To	Street end Numb wn, Stete)	ber or Rurai	Route Number,		
	To the Hospital of within 24 hours at To the Funeral D completely filled it	edical C	29e. Certifier 1 Ce (Check only one)	rtifying Phys dical Exami	sician: To the best ner: On the basis of end manner s	of examine	wledge, deeth tion end/or Inv	occurred et the estigetion, in m	tlme, dete y opinion, d	end pleca, steeth occurr	and due to the ed et the time,	ceuse(s) end ma dete end pleca,	anner as ste end due to	eted. the cause(s)		
	To the Within To the	Me	29b. Signature and title of	6rtifier	0.			29c. Lio	ense numbe	or		29d. Date signe	d (Month, E	Day, Year)		
	3		1/la	n/C	ele	_		0	2148	8		12-2	7-9	9		
	6		30. Name and address of participations of the second secon	erson who co	empleted cause of	deeth (Item	23e) (Type, I	Print)	1 m = 1	10	2050.	11	710	76		
	Sta	te	31. Dete filed (Month, Day, Year) 32. Registrer's Signeture								7'					
	Registr	-	DFC 2 8	1999	A .		14		1.							

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			Certificate	UI Dealii		Reg. No.		
Physicia	RULLI RODLIISON I	-			2. Date of Dec Month December	Dav	1999	3. Time of Death 7:00 p.m.
/Medica Examine	An English Manne // max inchibition mi-			4b. City, Town, or Leonard	Location of Death	4c. County		
Funeral Director	003-03-0023	Sex 7. Age (In yrs. 84	last birthday) If Under 1 Y Yrs. Months D	ear If Under 24 Hr ays Hours Mir			9. Birthpl Coun Mair	lace (State or Foreign try)
deeth with the Meryland one 23e or 23e4 show result be notified at	Usual Residence of Decedent 10e. State 10b. County Maryland St. Mar		y, Town or Location exington Parl	<			10	0d. Inside City Limits 1 ☐ Yes 2 ■ No
th with the 23s or 28s	10e. Street and Number 21515 Essex Drive	South	10f. Zip Co	20653		10g. Citizen of V United		•
j 22	10e. Street and Number 21515 Essex Drive 11. Meritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ■ No If Yes, Give	,S. 13. Was Decedent If Yes, specify	of Hispanic Origin? (Cuban, Mexican, Pue No Specify:	Specify Yes or No rto Rican, etc.)		ea - Americ ck, White, c	etc.
within 72 ho	15. Decedent's E (Specify only highest on Elementery/Secondery (0-12) 12	Yeer or Dates: ducetion ede completed) College (1-4or 5+)	16a. Decedent's Usuel O (Give kind of work d life. DO NOT use n	ccupation lone during most of we atired)	orking	16b. Kind of B		
aryland 2 should be filed ad Mental Hygic marked other matic event, is	Frank Yeaton)			ame (First, Middle, O McInti		10)	
	19a. Informant's Name/Relationship (Delores Grant, Fr		19b. Mailing Address (S 21515 Essex					
mon seges ant of tr. If it y or o	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special	Removal from State Met	Place of Disposition (Neme cometery, crematory or othe cropolitan Cre	of r place) ematory	Date 12-24-99	20c. Location		wn, State Virginia
Baltim permit. Pe Depertmen important: any Injury once.	21. Signetate of Funerel Service Lice	M33-	22. Name and A 22955 He	ddress of Facility Br ollywood R	insfield d., Leon	Funera. ardtown	l Hom	e, P.A. 20650-0279
Physician /Medical	23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.		f dying, such as cardio	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
Examiner	resulting in death)	Due to (or es e consequence of):	U.				IOYNS
ox 68760, certificate be assecuted right physician and use as the burial-transit	Sequentially list conditions, if any, leading to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Part tt. Other significant conditions of the condition	Due to (c. Prorend Due to (c.	or as a consequence of): CMUTHE MIN or as a consequence of):	ratinitud Sophi				
	Part II. Other significant conditions of	d.		e given in Part I	23b. Did	tobacco use co	ntribute to	the cause of death?
	unes bo	worrs hears.		3		Yes 2□ No		babty 4 Unknown
Division of Vital Records, or attending Physician: The law requires the first cleath. Director: After this certificate has been signed in by the funeral director, page 2 should be contact.					24a. Wes	en autopsy rmed?	av	ere autopsy findings ailable prior to mpletion of cause death?
of Vital Ripperson: The inthis certificate he ral director, page	25. Was cese referred to medicel exeminer?	Hospital:		Other:	eeth (Check only	one)		Yes 2 No
Attending Physics of Court of the funeral director. After this of by the funeral director.		28a. Date of Injury (Month, Dey Year)		Injury at Work? 1 Yes 2 No	Home 5 Resi	how injury occur		y)
Division of the three of the th	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, factory, or fy)	ffice	28f. Location (City or To	Street and Numi wn, State)	ber or Rura	il Route Number,
Divisir To the Hospital or Attent within 24 hours effer deat To the Funeral Director: completely filled in by the	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exar	nysician: To the best of my knominer: On the basis of examine and manner stated.	owledge, death occurred at tation end/or investigation, in	he time, date and place my opinion, death occ	ce, and due to the curred at the time,	cause(s) and m date and place,	anner as s and due to	tated. the cause(s)
To t Com	29b. Signeture end title of certifier	Thui LA	D	34539		29d. Date signe Decembe		
	30. Name and address of person who Khalid M. Husain,			d., Califo	rnia, MD	20619		
State Registra	31. Dete filed (Month, Day, Year)	32. Registrer's Signa	eture					

t and print not an armed the former

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth **Physician** Month 012 31 99 /Medical 4b. City, Town, or Location of Daath 4e. Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner 0801 nai Baltimore If Undar 24 Hrs. If Under 1 Year Birthplece (State or Foraign Country) 5. Social Security Numbar 6. Sax 7. Age (In yrs. lest birthday) **Funeral** Deys Months Hours 1 M 2 K 243-03-0368 Yrs. N.C Director Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Battomore 1 Yea 2 No Director Ma 10e. Street end Number 10f. Zlp Coda 10g. Citizan of What Country? +25 telahts 21215 14. Race - American Indien, Funeral 12. Was Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Maxican, Puarto Rican, atc.) 11. Marital Status Bleck, White, etc. 1 Navar Married 2 Merried ☐ Yes 2 No Yes, Giva 1□ Yas 2D No Specify: Black þ 3 Widowed 4 □ Divorced Yaar or Detes: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Private Homes permit. Pagas 1 and 2 should be filed wit Department of Health and Mental Hyglans Important: If Item 27 is marked other tha any filury or other traumatic event, Its angles omestic 10th grade NA 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be Nathan Gracie Williams 2 19e. informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) 420 Hark Baltond Avenue Vonne - bryardyas Larker Heights 20b. Plece of Disposition (Nama of 20e. Method of Disposition Dete 20c. Location - City or Town, Stete cematary, cramatory or other place) 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramovai from Stete Memorial Park 1-6-2000 4 ☐ Donetion 5 ☐ Othar (Specify) troutus 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Wabash Se a 23a. Pattl Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or hear failure. List only one cause on each line. Approximeta Interval Between Onaet and Death Physician /Medical Immediete Causa (Finel 16913 diseasa or condition resulting In death) Dua to (or es Examiner leso Sequantially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initialed events rasulting in death) Lest Due to (or es e consequence of): Physician/Medical e to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probebly 4 Unknown þ 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24e. Wes an eutopsy performed? 2/2 No 25. Wes case referred to medical examiner? Be 28. Placa of Death (Check only one) 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas 3 DOA 1 ☐ inpatient 2 ☐ ER/Outpatient 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. injury et Work? 28d. Describe how Injury occurred 5 Pending invastigation Netural 1 ☐ Yes 2 ☐ No 2 Accidant

Examiner or Attending Physician: The law requires that the death certificate be asscuted physician and s the burial-trans Division of Vital Records, P.O. Box 68760, signed by the attending d be datached for use as been si cartificata has biractor, paga 2 s diractor, this lunaral Aftar n 24 hours after death.

• Funeral Director: After plately lilled in by the lur Hospital

Pagas 1 and 2 should be filed within 72 hours after death with the Maryland

Hygiena.

Baltimore, Maryland 21215-0020

r than "natural", or items 23a or 28a-f ahow the Medical Eventiner must be notified at

To the Hosp within 24 hor To the Fune complately ii

State Registrar

edicai

29b. Signature and title of certifier 19cam

6 Could not be determined

29c. License number

12 Certifying Physician: To tha best of my knowledge, deeth occurred et the time, data and piece, and due to tha cause(s) end menner es steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et tha time, data and piace, and dua to tha cause(a) end mennar statad. 29d. Dete signed (Month, Day Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Name end eddress of person who complated causa of daath (Itam 23a) (Type, Print)

Amgrar lacem

31. Dete filed (Month, Dey, Year) JAN 0 6 2000

3 ☐ Suicide

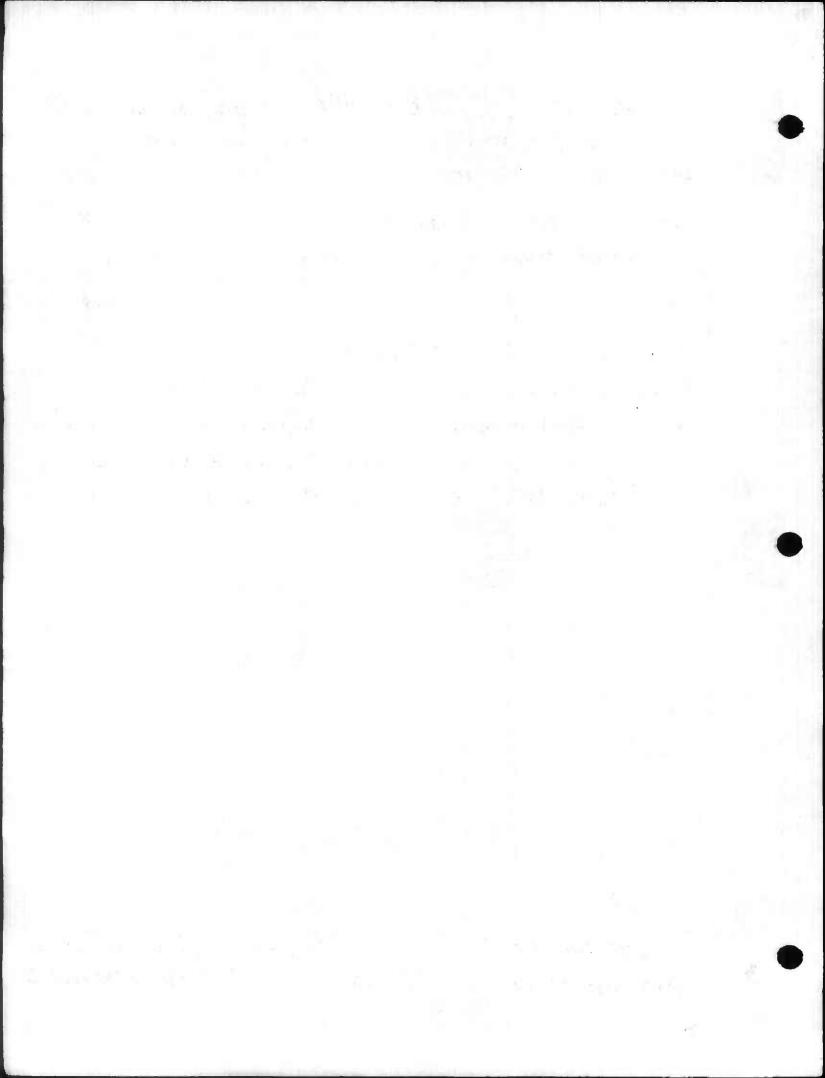
29e. Certifiar

4 Homicide

(Check only one)

32. Registrar's Signeture

28e. Plece of Injury - At home, ferm, streat, fectory, office building, etc. (Specify)



Registrar

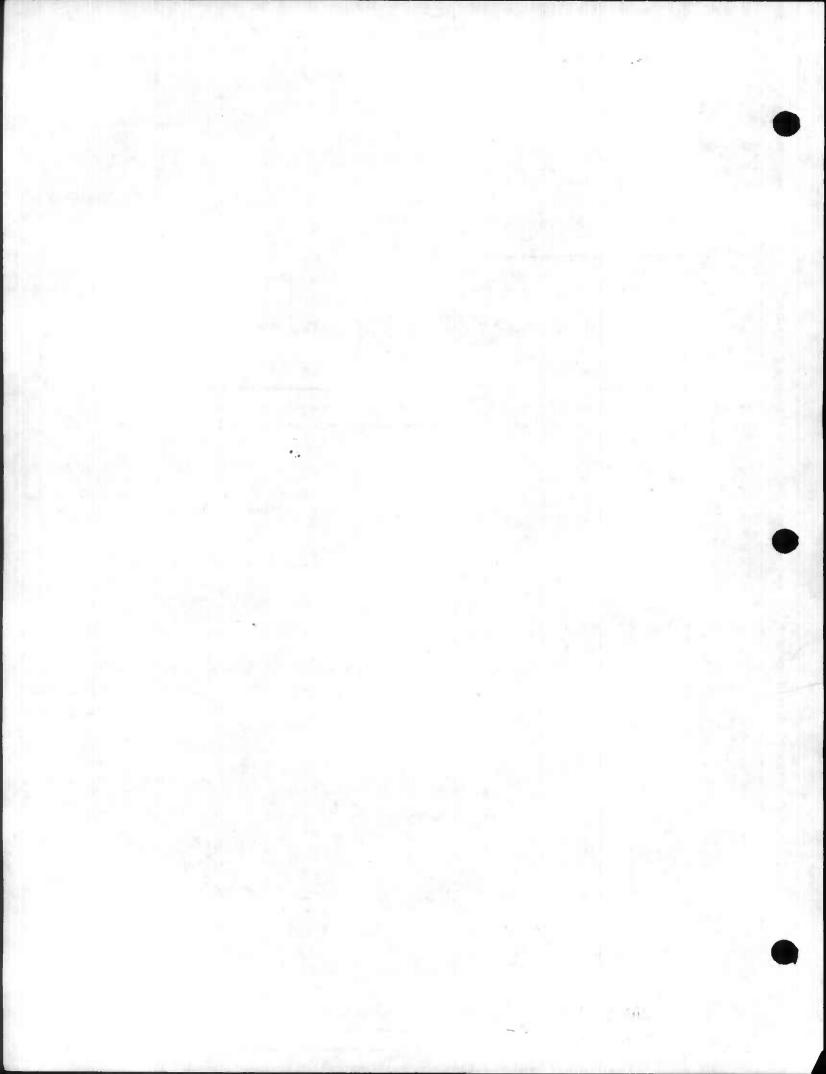
State

for the lat

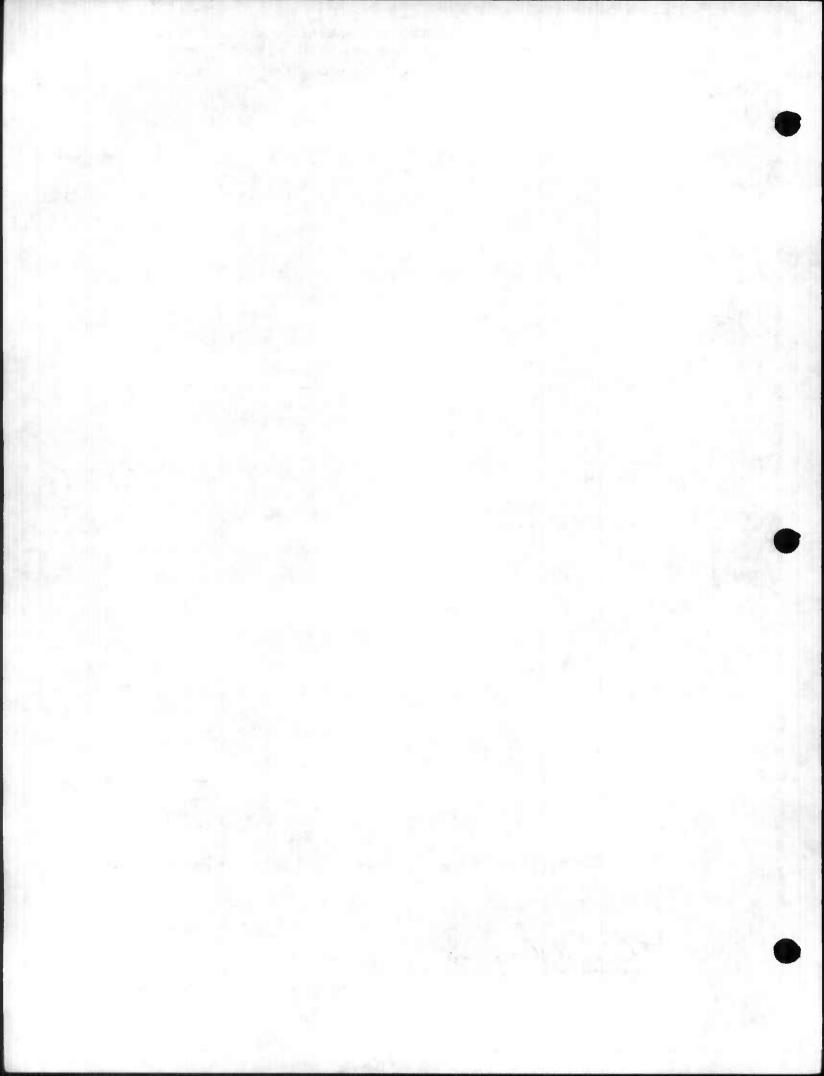
31. Data filed

0001

37. Ragistrar's Signatura



DHMH 16 Rsv 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $9\,9\,$ Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month **Physician** Floyd BROOKS ROBERT 1999 1.08 Am 12 31 /Medical 4a Facility Neme (If not institution, give street end number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimer Long Green, Genesis If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year, Sept. 24, 5. Social Security Numbe 253-01-2898 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXX M 2 F 95 Vrs 1904 Director Usual Residence of Decedent with the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show r than "naturel", or items 23a or 28a-f should be motival Examiner must be notified at Md. n/a Baltimore XX Yes 2 □ No Directo 10f. Zip Code 10g. Cifizen of Whet Country? 10e. Street and Number 1003 E. Coldspring Lane 21212 USA death v Funeral 14. Rece - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Status filed within 72 hours after Hygiana. 1 ☐ Yes 2 X X of the Yes, Give 1 Never Merried 2 X Tarried Specify: Black 1 Yes 2KNo n Yes, Give Yeer or Dates þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Director of County Elementery/Secondary (0-12) Branch Manager Mutual Ins. Agents Mutual Benefit other 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fether's Neme (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Ity Important: if them 27 is marked oth any liqury or other traumatic event page. John Brooks Hannah Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) C. Elizabeth W. Brooks wife 1003 E. Coldspring Lane Baltimore, Md. 21212 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date 20a. Method of Disposition XI Buriai 2 ☐ Cremation 3 ☐ Remova Imm State New Cathedral Cemetery Jan. 5 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funeral Service Literature 2501 Gwynns Falls PKWY Baltimore, Md. 21216 mess arri 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death to not enter the mode of dying, such es cardiac or respiratory errest, **Physician** Immediate Cause (Finet disease or condition resulting in deeth) /Medical Dely dration **Examiner** nsequence of) 1 week Examiner veunoria Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be execu attanding physician of for use as the buriel P.O. Box 68760, Physician/Medical Due to (or as a consequence of) ed by tha a Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobecco use contribute to the cause of deeth? 1 Tes 28 No 3 Probably 4 Unknown signed by Division of Vital Records, ρ 8 24b. Were eutopsy findings available prior to completion of cause of deeth? Aftar this cartificata has been si funaral director, paga 2 should Completed 24a. Wes an eutopsy performed? 1 ☐ Yes 2 No 1□Yes 2□No or Attending Physicien: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 27. Manner of Deeth 28d. Describe how injury occurred Certification: 1 Netural 2 Accident 5 Pending investigation after death.

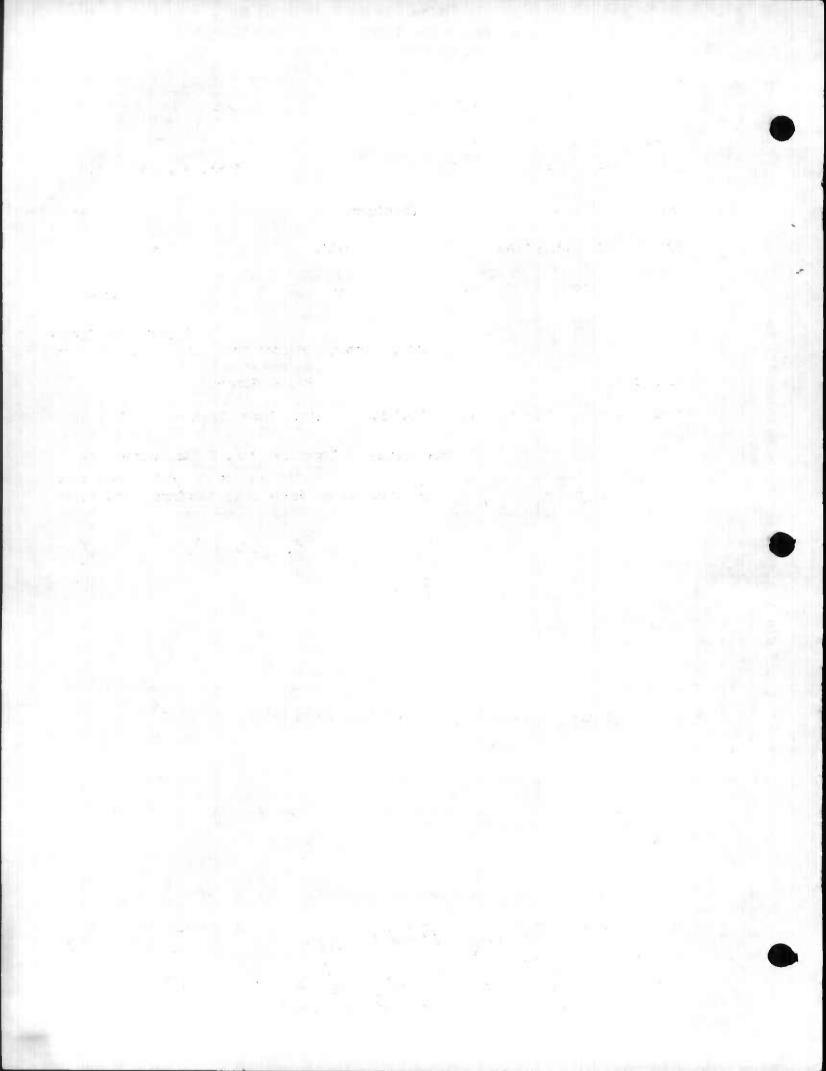
Director: Aft
d in by the fur 1 Yes 2 No 3 Suicide 6 Could not be 28e. Piace of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Mospital within 24 hours a To the Funeral Completaly filled Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and menner stated. edicai 29e. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of bart 29c. License number s of parson who completed cause of deeth (Item 23e) (Type, Print) WARTZM.D 31. Dete filed (Month, Day, Year) 32. Registrar's Signeture State 0 6 2000

Sepera

Registra

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Ce	ertificate	of Death		Reg. No.	9 4	1704
District Control	1. Decedent's Name (First, Middle, L	ast)				2. Date of De	ath Day	Year	3. Time of Death
Physicia /Medica	Harry	inthrop	Bailey			Month 12	19 19	999	10.20am
Examine	An English Name (Mant Institution -				4b. City, Town,	or Location of Deat	4c. County	of Death	
*	Good Samaritan	Hospital			Balti	more	Balti	imore	
Funeral	5. Social Security Number 6.		yrs. last birthday	Months D	ear If Under 24 I	Hrs. 8. Date of Bir Min. (Month, Da	th iv. Year)		ace (State or Foreign
Director	213-05-0220 Usual Residence of Decedent	1⊠M 2□F	88 Yrs.			02-02-		Balt	ímore
how I	10a. State 10b. County		City, Town or I					10	d. Inside City Limits
N THE	Md . N/A 10e. Street and Number		Baltimo	re					1X Yes 2 No
E 72	10e. Street and Number			10f. Zip Co	de		10g. Citizen of V	fhat Count	197
A 82		nue		212	14		1	ISA	
ter death with the Mender flems 23s or 28s-f show	5511 Edna Ave 11. Marital Status 1 Never Married 210 Married	12. Wes Decedent Ever i Armed Forces?	n U,S. 13	. Was Decedent		(Specify Yes or No	- 14. Race	e - America	
, o	3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2X		deno Filcan, etc.)	Specify	white, e	
n 72 hours	15. Decedent's l	Education	16a. Dec	edent's Usuel O	ccupation		16b. Kind of Bu	siness/Ind	ustry
4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	15. Decedent's (Specify only highest g Elementary/Secondary (0-12) 1.2	rade completed) College (1-4or 5+)	(Giv	e kind of work d DO NOT use n	one during most of etired)	working			
flied within Hyglene. ther then	12	College (1-401 54)	Ac	countant			Paper	Comp	any
be filed dither of other event,	17. Father's Name (First, Middle, Las	nt)			18. Mother's	Neme (First, Middle	Maiden Sumam	Θ)	
should be and Mentel marked o	Jacob H. Bailey				Emma	Dietrick			
2 should end Men le marke	19a. Informant's Name/Relationship	(Type, Print)	19b. Mei	ling Address (Si		Rural Route Numb	er, City or Town,	State, Zip	Code)
and 2 sho eith end 27 is m	Mrs. Vivian Baile	ev- Wife	551	1 Edna	Avenue	Baltimore	Md 212	1/	
or other tr	20a. Method of Disposition		b. Place of Disc	position (Neme o	of	Date	20c. Location -		vn, Stete
	1)OXBurial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec	ity)	laney '		emetery	12-23-99	Timoni	um, M	ld.
permit. P Depertme Importan eny Injury ands.	21. Signature of Funeral Service Like	li L'ovann	1		ford Rd,	Leonard Baltimore			al Home
	23a. Part1. Enter the disease, or con shock, or healt-failure. List onl	nplications that caused the c						1	Approximate Interval Between
Physician / /Medical	Immediate Cause (Final disease or condition				cident-St				Onset and Death
Examiner	resulting in death)	a. Due t	o (or as a conse	equence of):					
				Infarct	ion				
cete be executed physicien and the buriel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ————	o (or as a conse						
E 0	that initiated events resulting in death) Last	Due to	o (or as e conse	equence of):					
de th oe trandir d for use	Part II. Other significant conditions Hyper Tens					1			
d by the	Part II. Other significant conditions		resulting in the	underlying caus	e given in Part I.				the cause of death'
£ X D .	Hyper Tens	ion				_ 10	Yes ZU No	3 Prob	ably 4 ₺ Unknow
Physician: The law requires that the death of this cartificate has been signed by the attending director, page 2 should be deteched for use							an autopsy omed?	ava	re autopsy tindings itable prior to apletion of cause leath?
The level page 2	5					10	Yes 2 No	10	Yes 2□ No
certificete					26 Place of	Deeth (Check only			
Physicien: The rinis certificate hiral director, page		Hospital:	2 ☐ ER/Outpalie	ent 3 DOA	Other:	g Home 5 Resi		ne /Ennaih	1
eeth. cor: After this the funeral d		28a. Dete of Injury (Month, Day Yea.	-		Injury at Work?	7	how injury occurr		
Pred In by	2 Accident Investigation 3 Suicide 6 Could not determined	be 29a Place of Injury 4	at home, farm, s ecify)	treel, tactory, of		28f. Location (City or To	Street and Numb wn, State)	er or Rural	Route Number,
	29a. Certifier 12 Certifying P	hysician: To the best of my miner: On the basis of exam and manner stated.							
the standard of the standard o		and imperor stated.		29c. Li	ense number		29d. Date signed	d (Month, I	Day, Year)
0 1 × 100	1 1.	9.	MN						
Q,	duda	Sugar			3445		Decembe	ar 19	, 1999
W. 3	30. Name and address of person who	20		-					
Ok	Good Samartian	lospital 5601	Loch Ra	even Blv	d. Baltin	more, Md.	21239		
State	31. Date filed (Month, Day, Year)	32. Registrar's Si	neture	all					
Registrai	JAN 0 6 2000	person &	. 1000	RACE!					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Dete of Death 3. Time of Death Burks Month Vaar **Physician** Donald 1:05 PM December 27, 1999 /Medical 4b. City, Town, or Location of Deeth 4a. Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Baltimore Baltimore Rehabilitation and Extended care 7. Aga (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country)
 VA 5. Sociei Security Number 6. Sex 1√2 M 2□ F 224-20-1896 78 Yrs Director 6 - 12 - 21Usual Rasidence of Dacedant with the Marylenc 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumstic event, the Medical Examinar must be notified at MD Baltimore, 1 Yes 2 No Director 10e. Street end Number 10f. Zip Coda 10g. Citizan of What Country? 301 McMechen St. #1215 21217 USA Funeral deeth 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☑ ¥6s 2 ☐ No Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. Pepernit. Pages 1 and 2 should be filed within 72 hours effer (
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or ites any Injury or other traumatic event, the Medical Examinant Nevar Merried 2 Married

3 Widowed 4 Divorced 1 ☐ Yas 20 No Specify: Baltimore, Maryland 21215-0020 Specify: Black Š 16a. Decedent's Usuei Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast grade completed) 16b. Kind of Businass/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Disabled 11th 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Walter W. Burks Savannah C. Rhodes 19a. intormant's Name/Ralationship (Type, Print) 19b. Malling Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Donald Burks Jr-Son 923 Richville Rd. Standish Maine, 04084 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, Steta 20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from State NEW HOPE BApt, Church Cenetery 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility FUNERAL SERVICE VAUGHN C. GREENE 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrast,

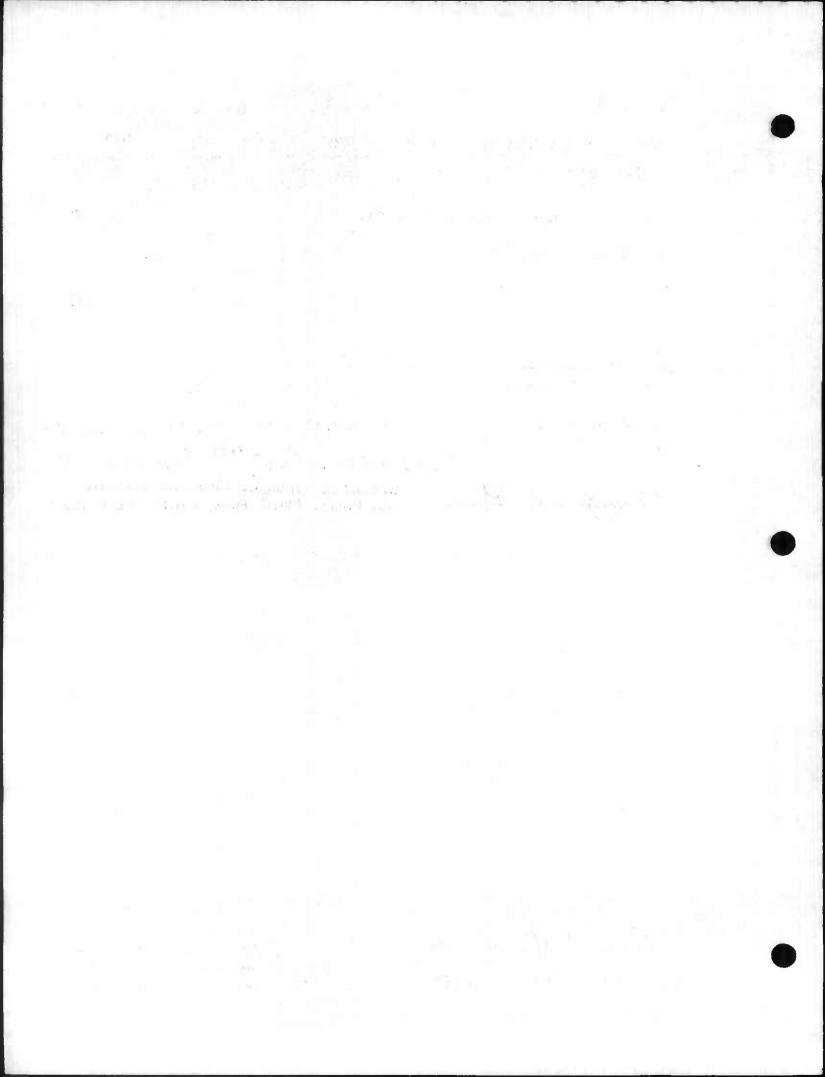
Approximate Approximete intarval Batween Onset and Death **Physician** CANCER OF THE PROSTATE /Medical immedieta Causa (Finai 2 years disaasa or condition rasulting in death) Examiner ettending physicien and I for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): Part ii. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yss 2 No 3 Probably 4 Unknown þ Completed 24b. Wara autopsy findings available prior to 24e. Wes en autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director; it 25. Was case raterred to medical 28. Placa of Death (Check only ona) examinar? Othar: 4 Nursing Homa 5 ☐ Rasidance 6 ☐ Other (Specify) 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Deta of Injury (Month, Day Year) 28c. injury et Work? 27. Mannar of Death Certification: 28b. Tima of 28d. Dascribe how injury occurred 1 (9Naturai 5 Pending 1 ☐ Yas 2 ☐ No Invastigation 2 Accident 6 Could not be datarmined 3 Sulcida 28a. Piace of injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicida 1 Certifying Physician: To the best of my knowledge, daeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. 29e, Certifian Medical 29c. Licansa number 29b. Signeture and title of certifier 29d. Data signed (Month, Day, Year) WWW W D0032548 December 27, 1999

30. Nema and addrass of person, who complated causa of daath (Itam 23a) (Type, Print) 10 NORTH EREENE STREET Baltimore, Maryland W COLVIN MD 31. Deta tiled (Morth, Day, Year) 32. Registrar's Signatura State JAN 06 2000 Registrar

DHMH 16 Rev 6/95



Box 68760, P.O. of Vital Records, Division

> State Registrar

31. Dete filed (Month, Day, Year)

(Check only one)

29b. Signeture end title of certifie

who completed cause of death (Item 23a) (Type, Print) m.D JACK M.

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

December 23, 1999

111 Penn Street, Baltimore, Maryland 21201

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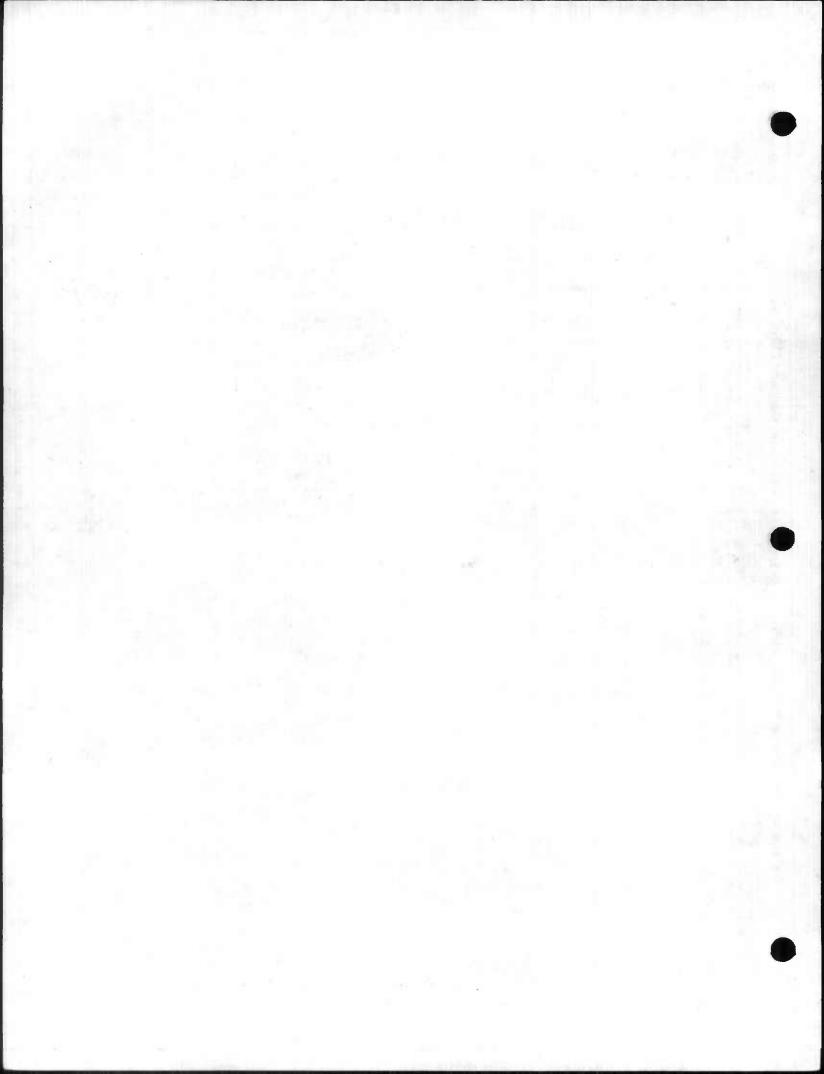
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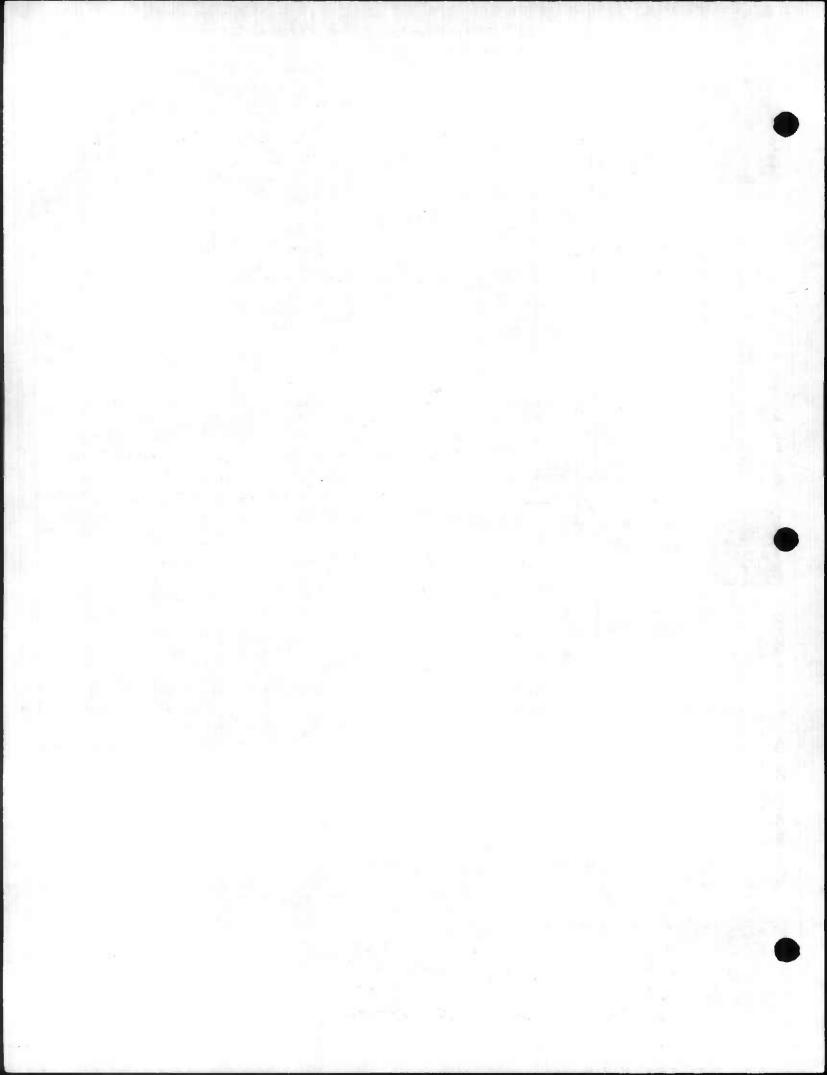


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Dev **Physician** Month Yee NETTIE GOTTFRIED 09:20 R 30 December /Medical 4a Facility Neme (If not institution, give street end number) 4b, City, Town, or Location of Death 4c. County of Death Examiner BALTIMURE CITY N/A 2401 WEST Belvider 5. Social Security Number HOSD In If Under 24 Hrs. If Linder 1 Year Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1□M 2ØF Hours 212-03-9934A Yrs. Director 99 OCT. 16, RUSSTA Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE MD BALTIMORE Director 1 ☐ Yes 2 ☐ No or 28s-f 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zin Code 1004 PARKVALLEY ROAD 238 21208 U.S.A. Funeral Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married ъ WHITE 1 Yes 2 No Specify Specify: þ 3 Widowed 4 Divorced Completed Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) SALESPERSON CLOTHING 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Sumeme) Be Pages 1 and 2 should be nent of Heelth and Mental reportant: If Item 27 is marked TANCHUM UNKNOWN **OSHRINE** 0 IDA SARAH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) IVAN OSHRINE / NEPHEW 1004 PARKVALLEY ROAD - BALTIMORE, MD 21208 20b. Place of Disposition (Name of cematary, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1X Buriel 2 ☐ Cremetion 3 ☐ Removei from Stete PETACH TIKVAH CEMETERY 01/05/2000 ROSEDAE, MD 4 Donetion 5 Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heart failure. List only one causa on aech lina. Approximata Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical **Examiner** The law requires that the death certificata be axecuted Sequentially list conditions, if eny, leeding to immediate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of 68760. 110 Physician/Medical the Due to (or es e consequence of): 9 Box (signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were eutopsy findings aveilable prior to completion of cause of death? page 2 should Completed 24a. Wes en autopsy 2 DAK 1 Yes 1 Yes 2 No Division of Vital Hospital or Attending Physician: director, Be 25. Wes case referred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28e. Dete of Injury (Month, Day Year) 27. Menger of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 5 Pending investigation 1 Naturel 1 ☐ Yas 2 ☐ No within 24 hours after death. To the Funeral Diractor: A 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 28e. Pieca of Injury - At homa, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. edical 29a. Certifier completely To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) addrass of person who completed cause of death (Item 23a) (Type, Print) McGast DEAN 32. Registrer's Signature 2401 West Belviden 31. Dete filed (Month, Dey, Year)

State

Registrar DHMH 16 Rev 6/95

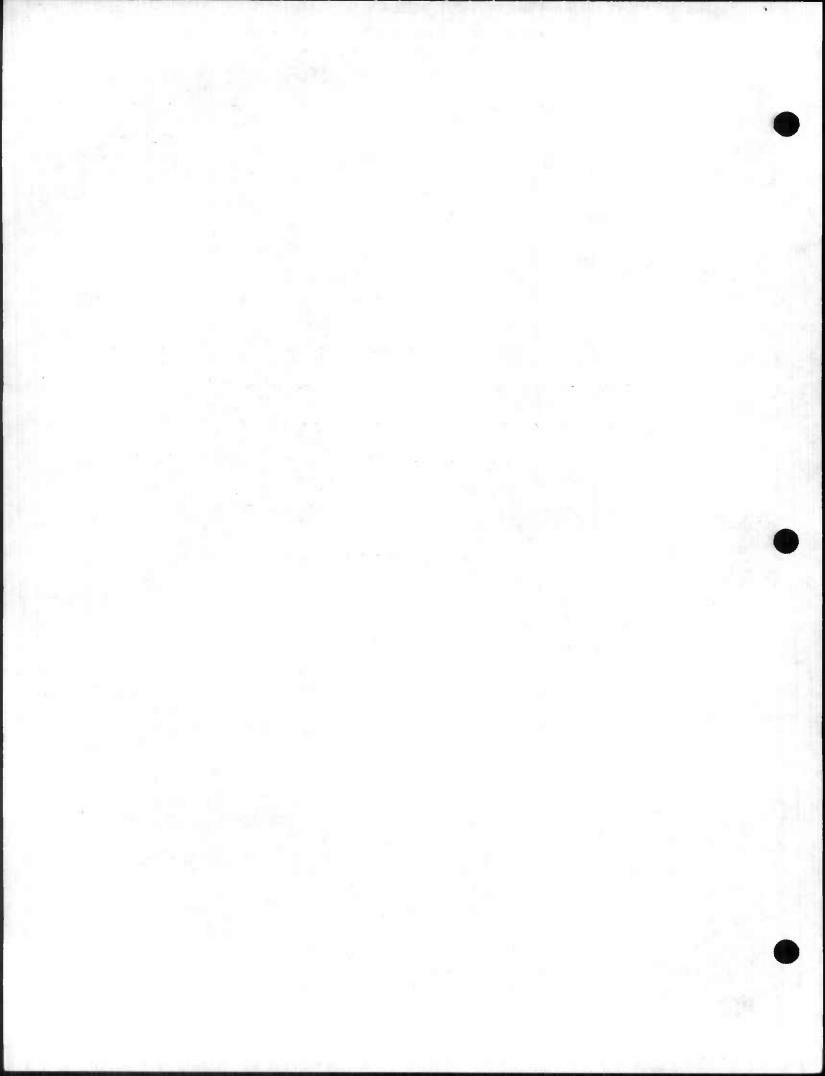
JAN 06 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

					State	of Mar	yland				lealth a Death	ind M	ental Hyg	giene Reg. No.	99	41	709
	1		1. Decedent's Name (First, F	Aiddle, Las	st)								2. Dete of Der Month	ath Day	Yeer	3. Tima	of Death
	Physici /Medic	_	John	Russ	ell Ga:	rvey						-	Decembe			10:4	41 AM
	Examin		4a Facility Neme (If not insti	itution, give	street and nu	umber)					4b. City, Tov	wn, or Lo	cation of Deeth	4c. County	of Death		
			St. Joseph 1	Medic	al Cen	ter					Towson			Balti	more		
	Funeral		5. Social Security Number	6. S	ex ⊠M 2□ F	7. Age ((In yrs. la	ast birthday)	If Under Months	1 Year Days	Hours	24 Hrs. Min.	8. Dete of Birt (Month, Day	h v. Year)	9. Birthple Country	ce (State	or Foreign
	Director		217-09-6012		MM ZUF		83	Yrs.					July 09		Maryla		
	pui *		Usuel Residence of Deceder 10a. Stata 10b. Co			1	I0c. City	, Town or Lo	ocation						100	d Inside	City Limits
	aho	5	30	timor	Δ.			onium									s 20 No
	Pie N	Director	10e. Street and Number	CIMOI	-		1.2111	OIII GIII	10f. Zip	Codo				10g. Citizen of \	Mhat Counts	2	
	with a or	ត់												Tog. Chizon or		,	
	filed within 72 hours after death with the Maryland Hygiens. rdher than "natural", or Herns 23a or 23e-f show art, the Marilest Examiner must be notified at	Funerai	2215 Mid:	ridge	Rd.	redent Ev	er in 115	3 13 1		093	lispanic Orio	nin? (Sne	cify Yes or No	14 Rac	USA e - Americer	n Indian	
	ter d	F	1 Never Merried 2	Married	Armed F	orces? 2⊠No	01 111 0,0		If Yes, spec	cify Cuba	an, Mexicen	, Puerto I	cify Yes or No- Rican, etc.)	Blad	ck, White, et		
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	gienu gienu	No.	12	-/				Logist	tical	Eng	ineer			Martin	Marie	tta	
Maryland	al Hygid I other Ivant, I	Be Completed	17. Father's Name (First, Mic	ddle, Last)										Maiden Suman	ne)		
χ	should be fond Mental I	2	Michael M.	Garve	У						Cath	erin	e Craig				
la	2 sho end is m		19a. Informant's Name/Rela	tionship (7	ype, Print)			19b. Mailir	ng Address	(Street	and Numbe	r or Aura	l Route Numbe	er, City or Town,	State, Zip C	code)	
	5 4 2 5		Mrs. Marie	Garve	y/ Wif	e					Rd.	Timo		D. 2109			
ore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Crama	tion 3 🗆	Ramoval from	Stala	CE	ace of Dispo metery, crer	matory or o	thar plac			Dale	20c. Location	City or Tow	n, State	
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Baltimore,	permit. Peges Department of Important: If I any injury or page.		21. Signature of Foreign Ser	vigilioen	100/	/	/	22			ss of Facility		owel He	mo Tno			
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			23a. Part1. Enter tha disaas shock, or heart failure.	or comp	cations that	caused the	e daath	. Do not ent	ter the mod	e ot dyir	ng, such as	cerdiac o	r respiratory a	rest,	1	Approxim nterval B	etween
	Physician		V. Carrier III	/												Onset en	d Death
18	/Medical Examiner		Immediate Cause (Final disease or condition	(a	Act	ute	Myoca:	rdial	Inf	arcti	on			1		
	LAdillilei	_	resulting in death)			Di	ue to (or	as a consec	quence of):						Į.		+
	D H	Examiner			b										1		
	be executed sician and burial-transit	xan	Sequentially list conditions, if any, leeding to immediate			Dı	ue to (or	es a consec	quence of):								
20,	be e ician burie	cal E	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or injury	~	c										i		
200	2 2 5		that initiated avents rasulting In daeth) Last			Du	e to (or	as a conseq	uence of):						1		
×	death certificet e attending phy ed for use as the	Physician/Med			d												
ROX	atten	clar															
5	the d	iysi	Part II. Other significant cor	nditions co	ontributing to d	leath but	not resu	lting in the u	inderlying c	euse giv	en in Part I.			lobacco use co			
7	ed by												10	Yes 2 No	3 Probl	ibly 4	Moukuown
B	law requires that the de as been signed by the a 2 should be detached	d by											24e. Was	en eutopsy			y findings
Hecords,	beer beer shou	ete											perfo	rmed?	com	lable prici pletion o eath?	f causa
T C	The lay	Completed											10	/oc 2536		Yes 2	25 alo
Vital	77	S	25. Was case referred to me	dical							26 Place	of Donth	(Check only o	A		163 2	2 140
	cert	To Be	examiner? 1 ☐ Yes 2 ☒ No	-	Hospitel:	Inpatient	2□6	ER/Outpatier	nt 32 DC	Oth	or:			dence 6 Oth	er (Snecify)		
5	Phys r this eral d		27. Manner of Death	1	28e. Date	of Injury		28b. Time o		8c. Injur		-		now injury occur			
0	iding Phy ith. : After thi e funeral	te		ending vestigation		nth, Day 1	rear)	Injury	М		Yes 2□!	No					
DIVISION	Attending Physician: ar deeth. ector: After this certific by the funeral director.	fice	3 ☐ Suicide 6 ☐ C	ould not be	28e. Plac	e of Injury	- At hor	me, farm, str	reet, fectory	, office			28f. Location (Street and Numi	ber or Rural	Route N	um <i>ber</i> ,
5	or Att	Certification:	4 Homicide		build	ling, etc.	(Specify)	,					City or To	vii, State)			
	To the Hoepital or within 24 hours after To the Funeral Direcompletely filled in b	edical	(Check only 2 Med		iner: On the b	pasis of e	xaminati							cause(s) and m date and place,			e(s)
	the the	Med	20h Signature and title of or	etific -	and mar	nner slate	d.		204	linana	e number			29d. Data signe	d (Month O	av. Yeer)
	To To		29b. Signatura and title of ce	A CO	00 -				290	. LIGHTS	IN THE STATE OF			Lou. Data signe	(inolay, b	ay, real,	
			Nonu	lel	lect	~~	0			D44:	271			12/2	7/99		
			30. Name and address of pe								03.5						
			Dr. Collecto 31. Date filed (Month, Day,)			donia Registrer's			nium,	MD	. 2109	13					
	Sta Registr		JAN 0 6 2000		120000		gignat	ADO.									
	negisti	214	JAN U O ZUUU	President		1 1/2		123000									

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth DEC. WILLIAM W. HYATT. SR. 8:20 A.M. 31, 1999 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GLEN BURNIE ANNE ARUNDEL MARINER HEALTH CARE If Undar 24 Hrs. 8. Date of Birth Hours Min. (Month, Dey, Yeer) If Under 1 Year 5. Social Security Numbar 7. Age (In yrs. lest birthday) Birthplaca (Steta or Foreign Country) 1 X M 2 □ F Days 80 Yrs 217-07-3588 AUG. 28, 1919 MARYLAND Usuat Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnslde City Limits MARYLAND BALTIMORE LANSDOWNE 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 204 4TH AVENUE USA 12. Was Dacedent Ever in U,S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, Whita, etc. 11. Marital Status Was Decedent of Hispanic Ortgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 Never Marriad 2 X Marriad 1 ☐ Yes 2 🗓 No Specify: WHITE 3 ☐ Widowad 4 ☐ Divorced 15. Decedent's Education (Specify only highast grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) MANUFACTURING SHEET METAL MECHANIC 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) GERMANTOWN, TN 38139 SON 2241 GLENALDEN DRIVE EAST, WILLIAM W. HYATT, JR. 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Date 20c. Location - City or Town, State 1 XBurial 2 Cramation 3 Removal from State 01 - 04 -LOUDON PARK CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MARYLAND 2000 22. Name and Addrass of Facility 4107 WILKENS AVENUE HUBBARD FUNERAL HOME, INC. BALTIMORE, MD 21229 he disease for complications that caused the death. Do not anter tha mode of dying, such as cardiac or raspiratory arrast, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 2 No 1 Yas 2 HO 28. Place of Death (Check only one)

Physician /Medical Examiner

> end physician e

the

signed by t

peen : page 2 certificate

To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

The lew requires that the death certificete be executed

Box 68760.

P.O.

Records,

Division of Vital

Examiner

Physician/Medical

by

Completed

Be

Certification: To

Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

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items 23s death

"natural", or

permit. Peges 1 end 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once.

traumatic event, the Medical Examiner

Director

Funeral

by

Completed

Be

the Maryland

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting to death) Last

25. Was case referred to medical examiner? Hospitat: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Naturel 5 Pending Investigation 2 Accident 3 Suicide 6 Coutd not be

28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete)

29a. Certifier

1 Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Dey, Year)

29b. Signature and title of or

02519

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4710 PENNINGTON AVENUE, BALTIMORE, MARYLAND RICHARD E. FISHER M.D.

31. Date filed (Month, Day, Yeer) State

4 Homictde

32. Registrar's Signature

28c. Injury at Work?

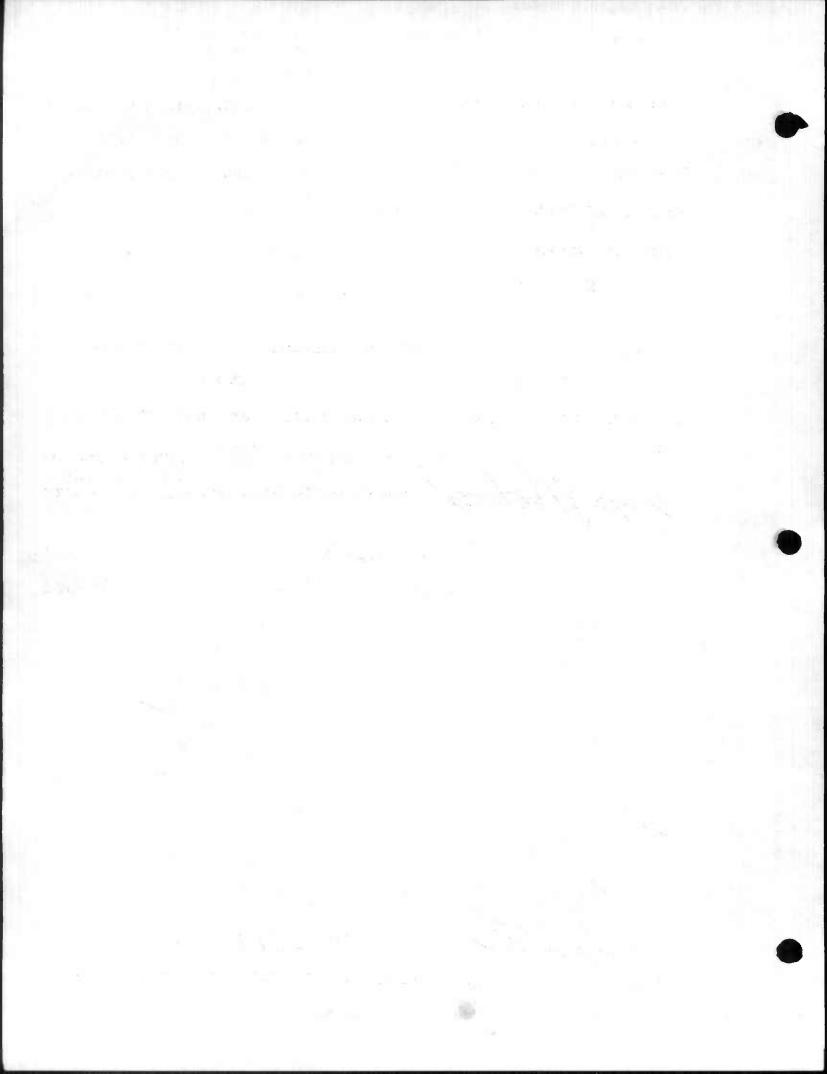
1 ☐ Yes 2 ☐ No

Registrar

10

DHMH 16 Rev 6/95

JAN 062000



/Medical The law requires that the deeth certificate be axecuted P.0. Records. Division of Vital or Attending Physician:

Examiner physician and the buriel-transit been signed by the s should be detached page 2 funeral director, this After n 24 hours after death.

• Funeral Director: Aft Hospital To the Hosp within 24 hor To the Fune completely fi

Examiner Physician/Medical þ Completed Be Certification: To

Physician

/Medical

Examiner

Director

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Norms 23s

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Physician

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72 hours after

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Baltimore,

29a. Certifier Medical

(Check only one) 29b. Signature end title of certifier 1. Surce

H45931

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

JANUARY 5, 2000

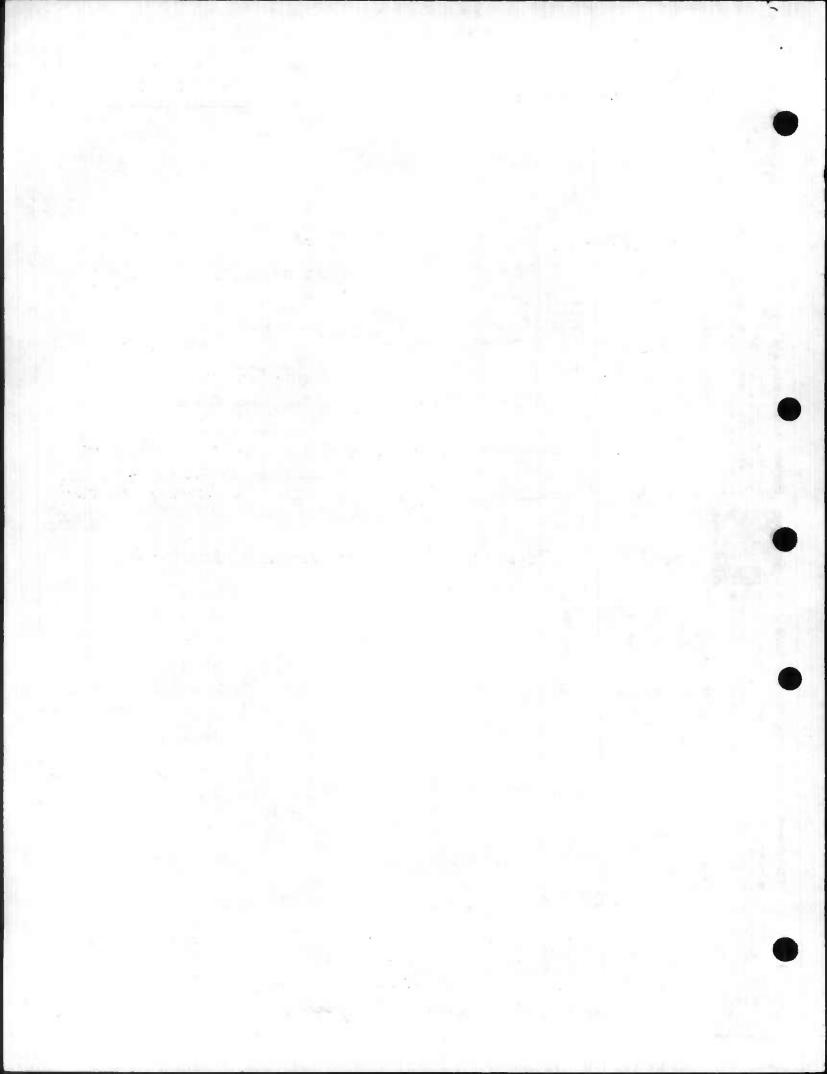
30. Name end addrass of person who completed cause of death (Item 23a) (Type, Print)

7220 PARK ITEIGHTS AVENUE BALTIMORE, MD 21208 I. Pierce Deborah 31. Data filed (Month, Day, Year)

State Registrar

32. Registraris Signature JAN 062000





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

	2 Date of Death			2.7	Time o	of D	-
Certificate of Death	Reg. No.				-	1	
State of Maryland / Department of Health and	Mental Hygiene	99	4	1	7	1	1
pe of Frint in black indenble line. Assure A	iii oopies Aie E	egible.					

Physician /Medical Examiner

4a Facility Name (If not Institution, give street end number)

4b. City, Town, or Location of Death

DEC.

1853 PM

1X Yes 2 □ No

Funeral

5610 YORK ROAD Unit 102 5. Social Security Number 7. Age (In yrs. last birthday) BALTIMORE

If Under 24 Hrs.

Hours

9. Birthplace (State or Foreign

Director

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natural, or

Hygiene. other than

Pages 1 and 2 should be nent of Health and Mental

or other tr

Department of any injury or ance

Director

Funeral

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Completed

Be

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Usual Residence of Decedent 10a State 10b. County

1. Decedent's Name (First, Middle, Last)

William Ralph

Months 10c. City. Town or Location

If Under 1 Year

Days

8. Date of Birth (Month, Dey Year) February 20, 1937 North Carolina

4c. County of Death

31° 1999

Maryland

205-28-2631

Baltimore

62

10d. Inside City Limits

10g. Citizen of What Country?

10e. Street and Number

5610 York Road Unit 102 10f. Zip Code 21212

United States

11 Marital Status 1 Never Merried 2 Merried

12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1957—
1962
1962

1MM 2□ F

 Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Ves 2 No Specify

 Reca - American Indian, Black, White, etc. Specify: Black

3 ☐ Widowed 4 ☼ Divorced

15. Decedent's Education (Specify only highest grade completed)

Johnson

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondery (0-12)

College (1-4or 5+) 4

Engineer

Hospital

17. Fether's Neme (First, Middle, Last)

William K. Johnson

18. Mother's Name (First, Middle, Meiden Sumeme) Sadie B. Williams

19a. Informant's Name/Reletionship (Type, Print)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
1215 Glen Faqle Road Baltimore, Maryland 21239

22. Name and Address of Facility

Louis Johnson/Brother

20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other paltimore National

20c. Location - City or Town, State 1/10/2000 Baltimore, Maryland

21. Signeture of Eymeral Service Licenses

Josta au an 23a. Pert1. Enter the disease, or complications that odused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

CAFA Stephen D. Lohmann P.A. 8717 Green Pastures Drive Baltimore, MD 21286

Physician /Medical Examine

sician and burial-transit

physician s the burial

signed by the a d be detached f

page 2 s hes

funeral director.

certificate

this

After

80 for use

The law requires that the death certificate be assecuted

Box 68760.

P.O.

Records,

Division of Vital or Attending Physician: Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of): Due to (or as a consequence of):

Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Immediate Cause (Finel

disease or condition resulting in death)

Due to (or as a consequenca of):

23b. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy periomed? INSPECTION 1□ Yes XXNo

26d. Describe how Injury occurred

24b. Were autopsy findings available prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

Approximate Interval Between Onset and Death

25. Was case referred to medical 26. Place of Death (Check only one) Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home XX Residence 6 Other (Specify)

XX Yes 2□ No 27. Manner of Death XXNatural 2 Accident

3 Sulcide

4 I Homicide

5 Pending investigation 8 Could not be determined 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work? 1 Yes 2 No

111 Penn Street, Baltimore, Maryland 21201

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

m.D.

1145

O.C.M.E

January 4, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACK 31. Date tiled (Month, Day, Year) State JAN 06

US, M. D. 32. Registrar's Signature

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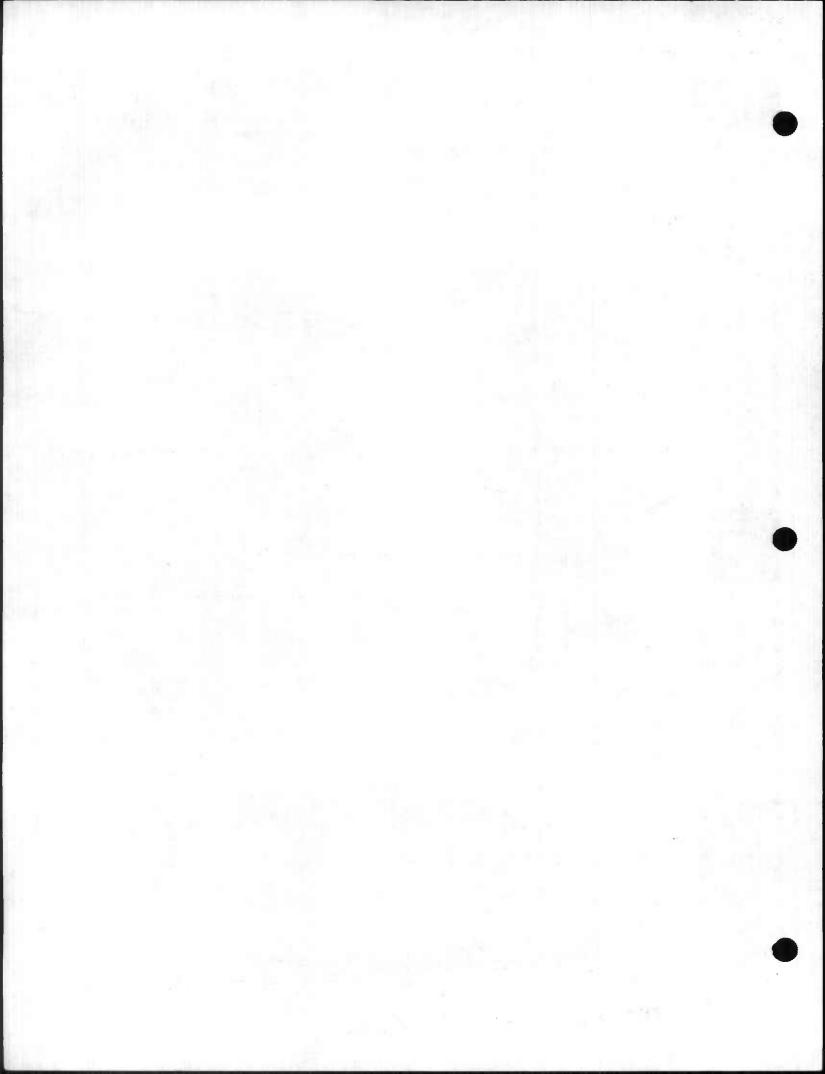
DHMH 16 Rev 6/95

ORIGINAL

within 24 hours after death.

To the Funeral Director: Al completely filled in by the fu \$ 0 Registrar

Hospital

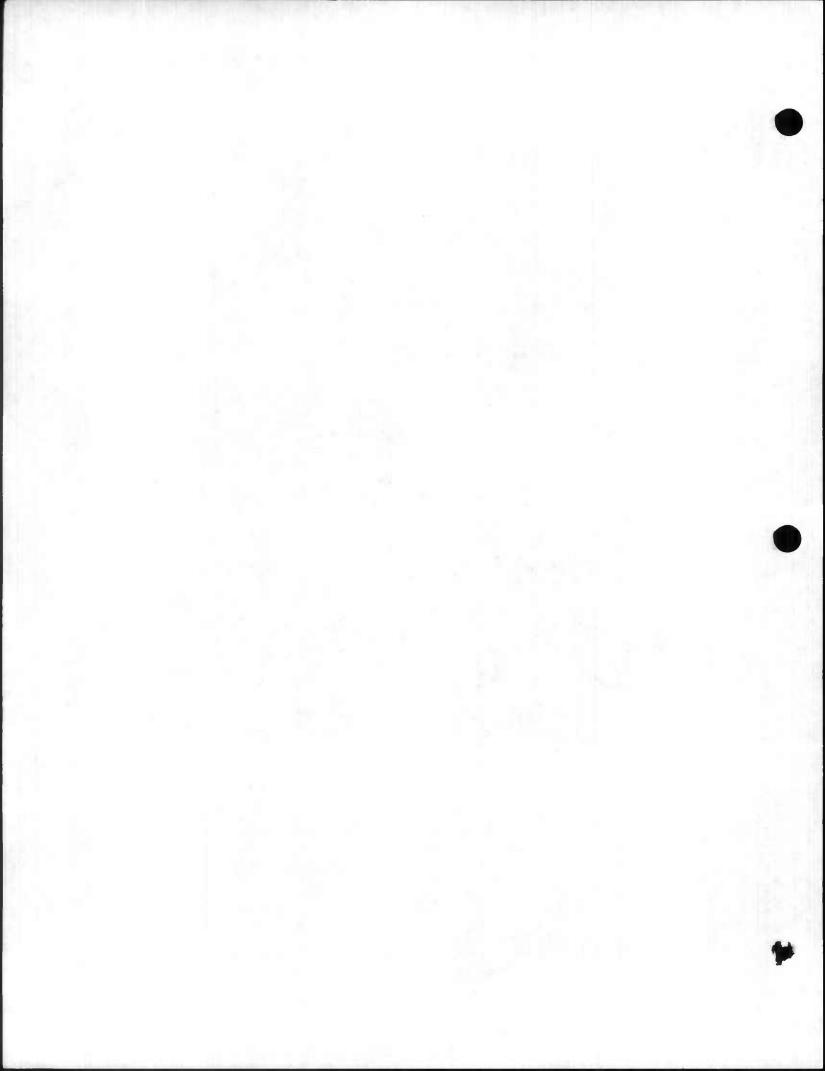


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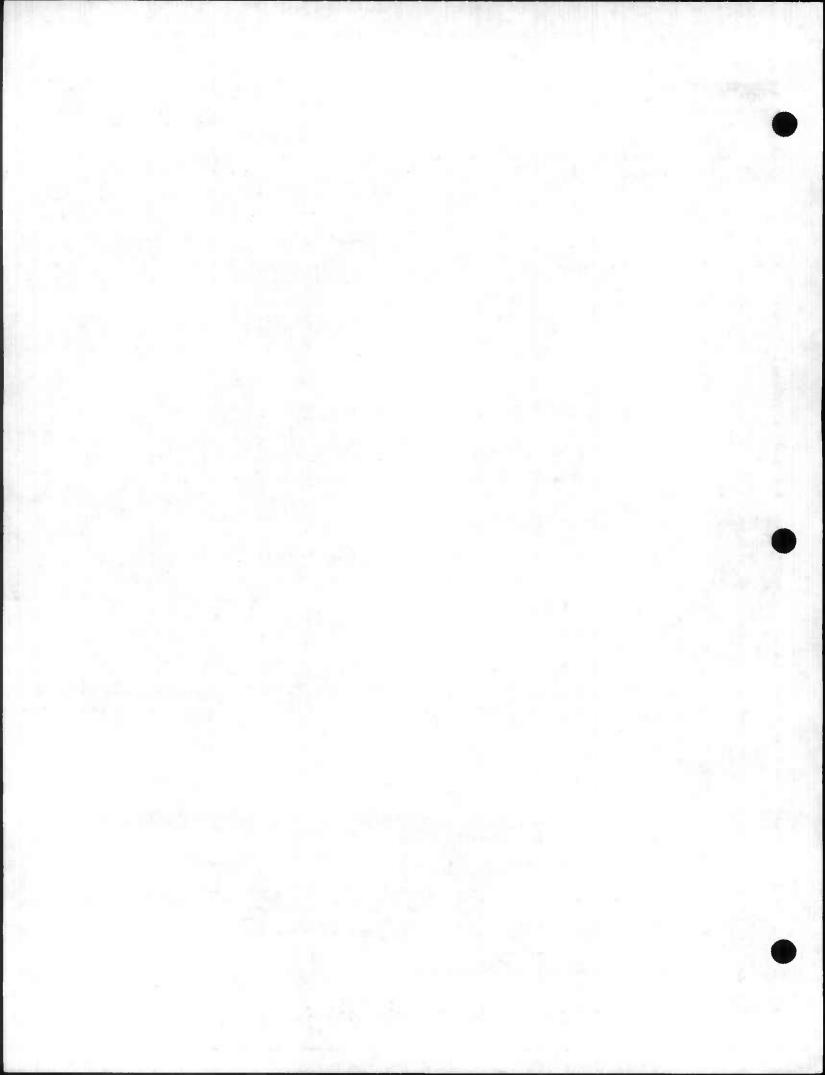
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TRICIA	State of Maryland / Department of Health and Mental Hygic

PATRICIA JONES		State of Marylan	d / Department of Certificate of		ental Hygien Reg. N	99 1	1714
Physician	Decedent's Nama (First, Middle, Last Patricia A. Jones				2. Data of Death Month D	ay Year 30,1999	3. Tima of Death 7:55P.M.
/Medical Examiner	4a Facility Nama (If not institution, giva SINAI HOSPITAL	street and number)		4b. City, Town, or Loce BALTIMORE		c. County of Death	
Funeral Director	217-44-9160	7. Aga (In yrs.		r If Undar 24 Hrs. 8 s Hours Min.	Data of Birth (Month, Day, Yea [arch II,	9. Birthp Coun 1944 Md	olaca (Stata or Foraign ntry)
Maryland fahow	Usual Residence of Decedent 10a. Stata 10b. County Md • n/a	10c. Cit	y, Town or Location	Baltimore		1	0d. Insida City Limits XXYas 2 □ No
Unter death with the Mainter death with the Mainter as 23s or 28e-f and the mast be notified. Furneral Director	10e Street and Number 1014 W. 43rd Stre	eet	10f. Zip Code	21211	10g. C	itizen of What Coun USA	itry?
Dy by	11. Marital Status XIX Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Evar in U Armed Forcas? 1 Yas PDNo If Yas, Giva Year or Datas:	S. 13. Was Dacedant of If Yas, specify Cu	Hispanic Origin? (Speciban, Maxican, Puarto Rio Specity:	ify Yas or No- can, atc.)	14. Race - Amaric Black, Whita, Specify: B	
T C	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Usual Occi (Giva kind of work don lifa. DO NOT usa retir School Teach	a during most of working red)	Bal	Kind of Business/Inc Ltimore C: Dlic Schoo	ity
Maryland 212: d 2 should be filed within and Mental Hygiene. T le marked other than traumatic event, the Maryland To Be Comp	Alvin P. Jones			18. Mother's Nama (Jewel Ogl		an Sumame)	
2 2 9 2 5	19a. Informant's Name/Ralationship (7. Jewel 0. Jones			street Bal			
Baltimore, N permit. Pages 1 and Department of Health Important: If I I I I I I I I I I I I I I I I I I	20a. Mathod of Disposition 12☐ Surial 2 ☐ Cramation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	Placa of Disposition (Nama of tematary, cramatory or other poutus Memorial	Park Ja	n. 6 Bal	Location - City or To	Md.
Ball permit Depart Import any in	21. Signature of Funeral Sprove Libers	Jany. X	2501 Gwyn	rass of Facility Nutt ns Falls PK	WY Baltin		
Physician /Medical Examiner	23a. Part1. Entar tha disaasa, or comp shock, or haart failure. List only of Immediate Causa (Final disaasa or condition rasulting in death)	a Arteriosclen	otic Cardiovas or as a consequence of):			 	Approximate Interval Between Onsat and Death
. Box 68760, death certificate be assected e attending physician and dofor use as the burial-transit siciar/Medical Examiner	Sequantially list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated avants resulting in death) Last	с	or as a consequence of):			1	
S, P.O. BOX 6: as that the death certific gned by the attending p be detached for use as by Physician/Mee	Part fl. Other significant conditions co	ntributing to death but not res	ulting in the underlying causa (givan in Part I.	23b. Did tobacc	co use contribute to	o the cause of death
ds, P.O. nires that the de signed by the ad be detached d by Physic	Diabetes Mellitus		61		-	T	bably 4 Unknow
aw requisite been 2 should	MORBID OBESITY				24a. Was an au performed? INSPECT: 1 Yas	ION co	are autopsy tindings railable prior to mpletion of cause death?
of Vita hysician: his certific al director. To Be	25. Was casa rafarred to medical axaminar? 1 No 27. Mannar of Death		EN Outpatient 3LI DOA		(Check only ona)	6 □Othar (Special	
ivision r Attending for death. irector: After n by the fune	1 Netural 5 Panding invastigation 3 Suicide 6 Could not be datarmined		Injury M 1	☐ Yas 2 ☐ No		and Number or Run	al Routa Number,
Hospi 4 hou Funer lasty fill			wledga, daath occurred at tha tion and/or investigation, in my				
To the To the To the complet	29b. Signature and title of certifier	Oly		nsa number		Data signed (Month, EMBER 31,	
	30. Nama and addrass of person who con David Fowler, M.D.	omplated causa of death (Item		n Street, E	Baltimore	, Marylan	d 21201
State Registrar	31. Data filed (Month, Day, Year) JAN 062	32. Registear's Signa	B Spa	uks		_ 3	

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Month 6:00P 1999 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death BALTIMORE H Under 24 Hrs. 8. Deta of Birth Hours Min. (Month, Day, Year) October 17, 1946 OF MARYLAND MEDICAL CONTOR UNIVERSITY If Linder 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 10 M XDF 53 217 46 3202 Maryland Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits **Baltimore** Baltimore 1 Yas 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 2919 Mallview Road 21230 IISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 🖾 No If Yas, Giva Specify: white 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Datas: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Technology Bookkeeper 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl Wolfe Mable (unk) 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Monk - husband 2919 Mallview Road, Baltimore, MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2XI Cramation 3 ☐ Ramoval from Stata Chesapeake Crematory 1/4/00 4 ☐ Donation 5 ☐ Othar (Specify) Beltsville, MD 22. Name and Address of Facility CAFA, Stephen D. Lohrmann, P.A. 21. Signature of Funeral Service Linear 8717 Green Pastures Drive, Towson, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immedieta Causa (Final disaesa or condition rasulting in deeth) Sequentially list conditions, if any, laading to immadieta causa. Entar Underlying Cause (Disease or Injury that Initialed avents rasulting in death) Last Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of seath? 1 Yes 2 No 3 Probably 4 Inknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2/2NO 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

MD

Funeral

Director

28a-f ahow

Director

Funeral

Completed by

Be

t than "natural", or items 23a or 28a-f ahor the Medical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene.

Ant. If fern 27 is marked other than "natural", or the may or other traumatic event, the Medical Examina

with the Maryland

21215-0020

Baltimore, Maryland

Box 68760,

P.0.

Division of Vital Records,

or Attending Physician:

Examiner Physician/Medical the US9 88 Medical Certification: To Be Completed by funeral director, s after des. al Director: Afte filled in by

certificata has

After this

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was casa rafarred to medical examinar? 1 Yas 20 No 27. Menner of Dealt of Injury onth, Day Year) 28d. Describe how injury occurred trijury st Work? Naturel 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicida 29a. Cartifian 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check only one)

To the Hospital o within 24 hours at To the Funeral DI completely filled is

UNIVERSITY OF MARKY HAND MEDICAL CONTER 31. Data filed (Month, Day, Year)

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29b. Signatura and little of contille

/32. Registrar's Signature

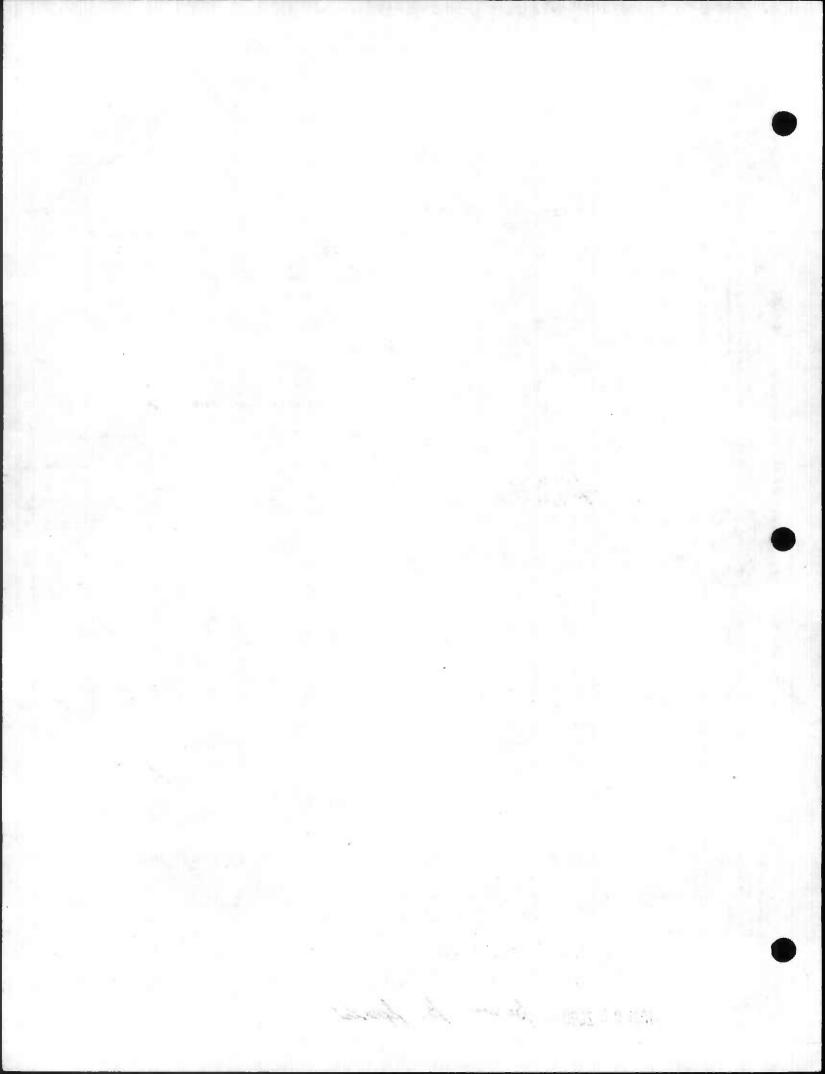
30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

22 South GREENE ST, BALTIMORE, MI)

29c. License number

29d. Data signed (Month, Day, Year)

MI



Baltimore, Maryland 21215-0020

4a Fecility Name (If not institution, give street end number) VA Maryland Health Care System 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Months Days Hours Min	ocation of Deeth int 8. Date of Birth (Month, Dey, Yea Mar 1, 192	Cecil 9. Bin Catizen of What Co	thiplece (State or Foreign ountry) MD 10d. Inside City Limits 1 □ Yes 27 No
John A. Morris 4a Fecility Name (If not institution, give street end number) VA Maryland Health Care System 5. Social Security Number 214-28-1249 Usual Residence of Decedent 10a. State 10b. County MD Cecil 10c. City, Town or Location Hebron 10c. Street and Number 209 W. Church Street # 15 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spatial Status) 14. City, Town, or Location Months 15. Age (In yrs. last birthdey) 16. City, Town or Location Hebron 10c. City, Town or Location Hebron 10f. Zip Code 10f. Zip Code 11. Was Decedent Ever in U,S. Armed Forces? 15. Yes, 29 No Specify: 16. Yes, Specify Cuban, Mexican, Puerto 17. Age (In yrs. last birthdey) 18. Months 19. Months 19. Months 10 Ab. City, Town, or Location 10 Age (In yrs. last birthdey) 11 Age (In yrs. last birthdey) 12 Age (In yrs. last birthdey) 13 Age (In yrs. last birthdey) 14 By Age (In yrs. last birthdey) 15 Age (In yrs. last birthdey) 16 Age (In yrs. last birthdey) 17 Age (In yrs. last birthdey) 18 Age (In yrs. last birthdey) 19 Age (In yrs. last birthdey) 10 Age (In yrs. la	Month December 2 ocation of Deeth 4 oint 4 oint 8. Date of Birth (Month, Dey, Year Nat 1, 192	Cecil 9. Bin 24	11:30 PM thiplece (State or Foreign ountry) MD 10d. Inside City Limits 1 □ Yes 27 No
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3 Widowed 4 Divorced Year or Dates: 57-61			white
15 Decedent's Education 18a Decedent's Decedent's Decedent		Specify.	MILLE
(Specify only highest grede completed) (Give kind of work done during most of work	ring 16b.	Kind of Business/	/Industry
Elementary/Secondery (0-12) College (1-4or 5+) 8 College (1-4or 5+) Security guard		govt	
	ne (First, Middle, Meide		
	ian Webb		
19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Run		or Town. Stete,	Zin Code)
Perry Point VA Medical Center Bldg 361 Perry Point,			.,
20a. Method of Disposition 1 □ Burlal 2 □ Cremetion 3 □ Removal from State 4 ☒ Donetion 5 □ Other (Specify)	Date 20c.	Location - City or	Town, State
21. Signature of Funeral Service Licensee Royald S. Wade, Director State Anatomy Board Baltimore, MD 2120		altimore	Street
23a. Per I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate tnterval Between Onset end Death
Immediate Cause (Final displays or condition a Congestive Hearth Failure			Unknown
resulting in death) a. Congestive fleater rational fleaters and the consequence of:			1
Pericardial Effusion			Unknown
Sequentially list conditions. Due to (or as a consequence of):			
if any, leading to immediate cause. Enter Underlying Atrial Fibrillation			Unknown
Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of):			i i
IDSURING IN GODERNY LESS			
d			
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.	23b. Did tobacc	co use contribute	e to the causa of death?
	1X Yes	2□ No 3□P	Probably 4 Unknown
Colon Cancer			
Chronic Obstructive Pulmonary Disease	24a. Was an eut performed?	, ,	Were autopsy findings available prior to
CHEOHIC ODSCINCTIVE FULLIONALY DISCUSS			completion of cause of death?

Physician /Medical Examiner Director

Funeral

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Completed

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Physician

/Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Pyglene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, in Medical Examiner must be notified at page.

attending physician and for usa as the burial-trensit

Physician/Medical Examiner

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Certification:

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director filled in by tha funeral or Attending 24 hours efter death Hospital within 24 hor To the Fune completely fi

Records, P.O. Box 68760, a Division of

Pert II. Other s Colon Chroni 1 Yes 24 No Insulin Dependent Diabetes Mellitus 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28b. Time of 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piaca, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and piaca, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Dey, Year)

Samu khew

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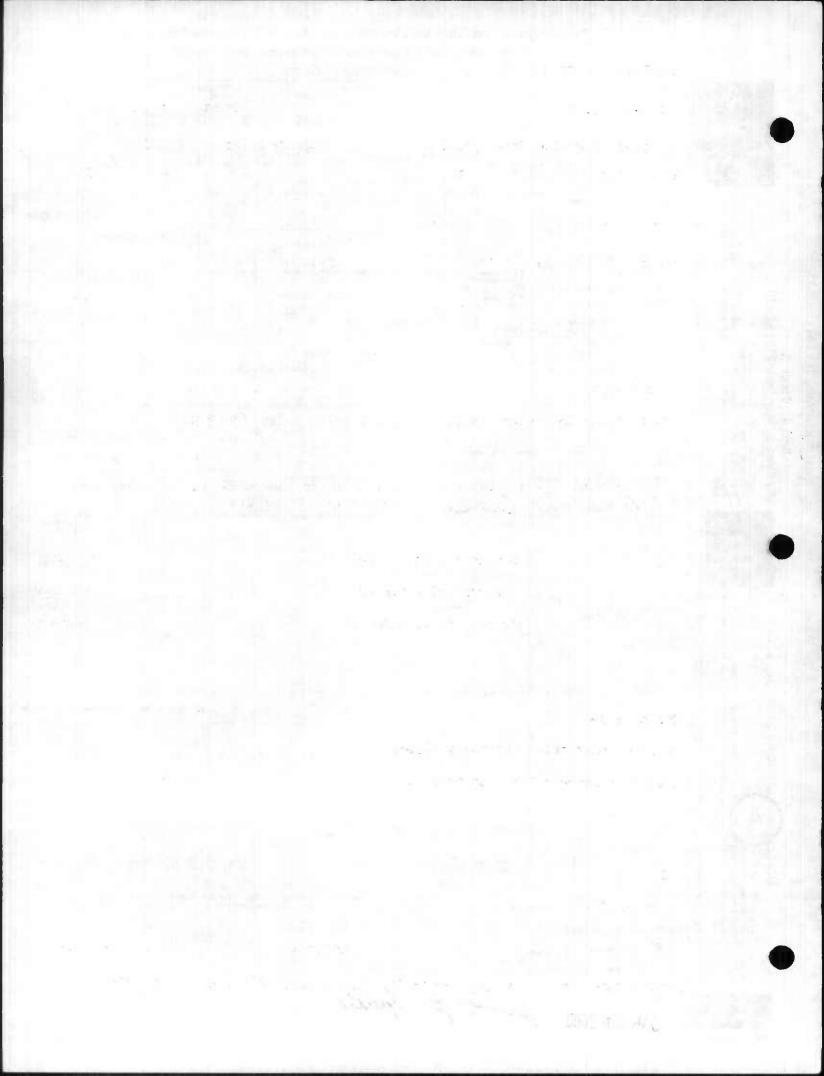
December 25, 1999

30. Neme and address of person who completed cause of death (item 23a) (Type, Print)

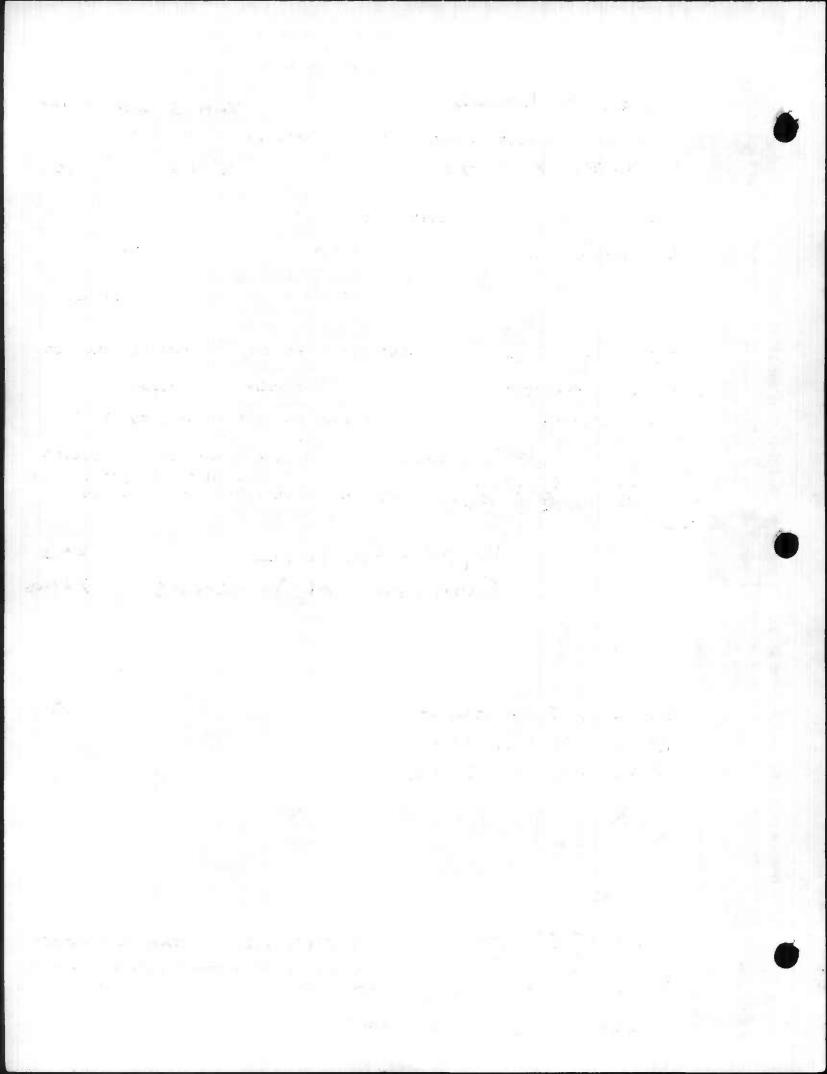
SAMIR KHEIRI, M.D., VA Maryland Health Care System, Perry Point, MD 21902 32. Registrar's Sloperure 31. Dete filed (Month, Day, Yeer)

State Registrar

JAN 0 6 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dey Month Yee **Physician** Lee Mel -ourin 0020 Jan 3 2000 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Johns Hopkins Bayview Med. Ctn. Baltimore If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Yeer Months Deys 5. Social Security Number 6 Sex 8. Dete of Birth Month, Day Year) 05-07-23 9. Birthplace (State or Foreign Country) **Funeral** 249-26-2341 10XM 2□ F Director Usuel Residence of Decedent the Maryland 10e Stete 10b. County 10c City Town or Location 10d. Inside City Limits "naturel", or items 23s or 28s-f show 1 Yes 2 □ No Baltimore Director NA MD 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21202 USA 842 Hartford Court death Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. of fled within 72 hours after de il Hygiena. 1 Never Merried 2 X Merried 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Yeer or Dates: Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) The Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction Co. Construction worker 3rd. Grade NA permit Pages 1 and 2 should be file.
Department of health and Mental Hygis important if flow 27 is merked any injury or other the page. 18. Mother's Name (First, Middle, Melden Sumame) 17. Father's Name (First, Middle, Last) Be Martha Pernell McLaurin Simmy 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 842 Hartford Court Baltimore, MD. 21202 Mary McLaurin 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Voshell Mem. Gardens 01-07-2000 Dundalk, MD Pegation 5 ☐Other (Spec 22. Name end Address of Fecility Baltimore, Maryland 21202 21. Signatupe Funeral Service Lie WM.C.March FH 1101 E.North Avenue a of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final Hepatic tailuve
bue to (or as a consequence of): 2 MOS disease or condition resulting in death) Examiner of Pancreas 3 HOS Examiner arcinoma physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medicai Due to (or es e consequence of) for use as signed by the a d be datached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably ETOH abuse Records, à 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed R HIP 10/95 24a. Was an autopsy peeu certificate has bliractor, page 2 s Rhumerus Fract 10/90 2 No 1 ☐ Yes 2 No 1 Yes Division of Vital Hospital or Attending Physician: 25. Was cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 this 28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury 27. Menner of Death 28d. Describe how Injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completaly filled in 162 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. edicai 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier D04383 JAN 03 2000 5505 Hopmis Bay view Circle 13a1T, no 21224 30. Name and address of who completed ceuse of deeth (Item 23e) (Type, Print) oughin treen Balt 32. Registrar's Signeture 31. Dete filed (Month, Day, Year) State Registrar JAN 0 6 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month McClelland December 27 1999 10:35 PM 09 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Geriatric Center Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 F Months Hours MD 217-26-8868 69 05-13-30 Usual Rasidence of Decedant 10a. Sfata 10c. City. Town or Location 10d. Insida City Limits 10b. County X1 Yas 2 No MD NA Baltimore 10e Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5501 Hopkins Bayview Circle 21224 USA 14. Race - American Indian, 12. Was Decedenf Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, Whita, atc. Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unknown NA Disabled unemployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Unknown Unknown 19a. Intormant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 300 Metro Plaza Baltimore, Maryland 21215 Herbert Holliday 20b. Place of Disposition (Name of cemetary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State *Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Voshell Mem. Gardens 01-06-2000 Dundalk, MD Signature of Funeral Segund 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, one cause on each line. Approximate Interval Between Onsat and Daath eft Neck Immediata Causa (Final disease or condition resulting in death) a. Metastatic Squamous Cell Cancer
Due to (or as a consequence ot): Retroperitance1 months Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated avants resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 2/2110 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Date of Injury (Month, Day Year) 27. Manpar of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be datamined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Cartifia: 1) Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examinar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: Hospitat within 2

Physician

/Medical

Examiner

Director

Funeral

by

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Pages 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Itema 23a or 28a-f ahow mit: If Item 27 is marked other than "naturel", or Itema 20a or 28a-f ahow mry or other thaumal be notified at my or other thaumal be notified at

Physician

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Physician/Medical Examiner

by

Completed

Be

Certification: To

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Baltimore, Maryland 21215-0020

State Registrar DHMH 16 Rev 6/95

31. Date filed (Month, Day, Year)
JAN 0 6 2000

29b. Signature and fitle of certifier

Jimmy Edmond MD, 5505 Hopkins Bayview Circle, Baltimore 32, Registrar's Signature

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

Sporks

29c. Licanse number

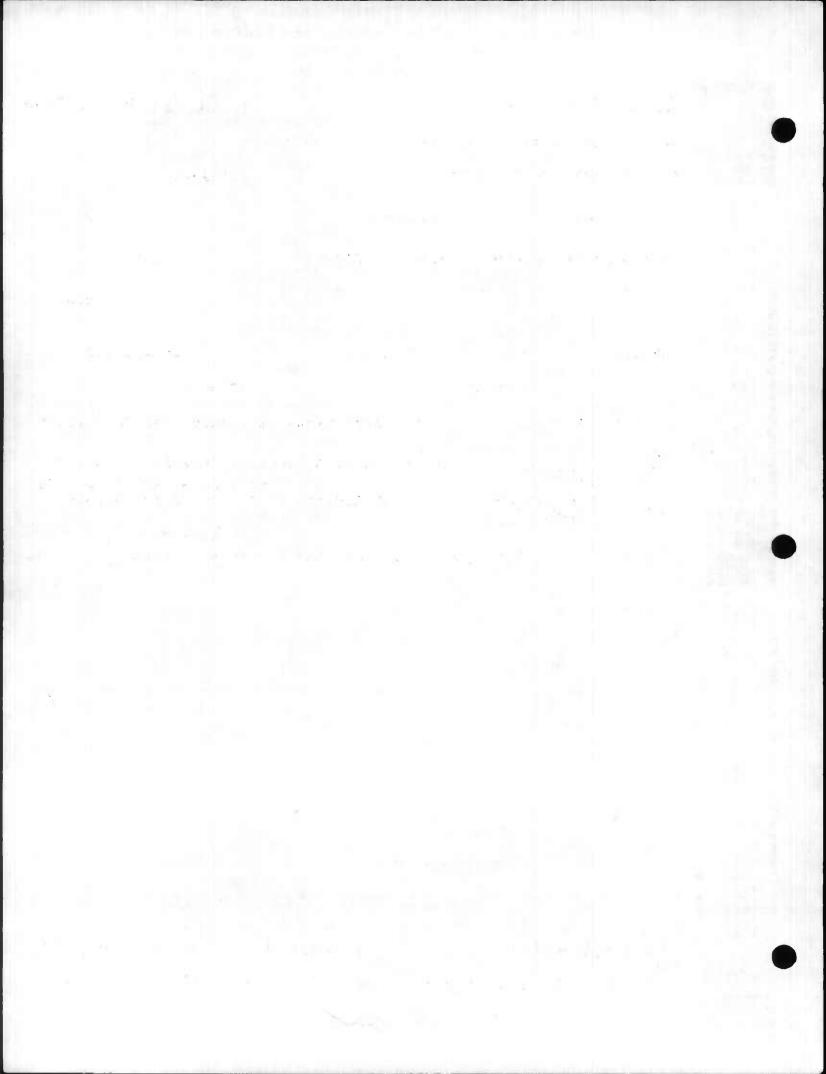
D0053124

29d. Data signed (Month, Day, Year)

Maryland

December 28, 1999

21224



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month Yaar **Physician** 5:39PM 28 1999 December Wilson Francis Machin, Sr. /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Gilchrist If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Hours 1QM 2DF Months Days 75 Yrs. Director Feb. 3 1924 Maryland 216-14-7330 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Directo Baltimore Timonium 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 14 Evans Ave. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status Was Decedent Ever in U,S. Armed Forcas? 14. Race - American Indian, Black, White, atc. 1 ☑ Yas 2 ☐ No If Yes, Giva Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: WWII Specify: 21215-002 à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9 Telephone Co. PBX Instructor 17. Father's Nama (First, Middla, Last) 18 Mother's Nama (First Middle Maiden Surnama) Pages 1 and 2 should be nent of Health and Mental Health and Mental em 27 le marked o Erma Marie Martin Sherman Asa Machin 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Evans Ave. Timonium, MD. 21093 Mrs. Thelma Machin/Wife Department of Health Important: If Item 27 altimore, 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) 8 Dulaney Valley Cem. 12-31-99 Timonium, MD. 21. Signature of Funaral Service Licen 22. Name and Addrass of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximata Interval Between Onset and Death Physician ESOPHAGENL /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The lew requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. ed by the attending physician detached for use as the burie Dua to (or as a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of degth? 1 Yes 2 No 3 Probably 4 Donknown rong Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vitai 25. Was case refarred to medical examiner? 8 26. Place of Death (Check only ona) 8 Hother (Specify) Hespel 1 Yas 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 Rasidence Certification: To this funeral 27. Manner of Death 1 DNatural 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Aftert or Attending 5 Pending invastigation ours effer death. heral Director: Aff filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital within 24 hours To the Funeral Completely filled edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(s) and manner steted. 29d Data signed (Month, Day, Year) 29b. Signatura and title of certified 29c. License number 030433 of death (Item 23a) (Type, Print). OHALLE) STREET 30. Name and address of person who completed cause MO 21204

DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month, Day, Year)

32. Registrar's Signatura

B. Sparks

and the

Please Type or Print in Black Indelibie Ink. Assure Ail Copies Are Legible.

Christopher Anton Nauman

State of Maryland / Department of Health and Mental Hygiene 99 41720

					Ce	rtificate	of	Death		R	eg. No.	40	1 1 ha O
	· · · · · · · · · · · · · · · · · · ·								2. Date of Dea Month		Year	3. Time of Death	
hysician /Medical										Decembe			12:48 P.M.
xaminer		(If not institution, given		ım <i>ber</i>)			1			ocation of Death	4c. County	of Death	
,		lfs Warf	Road					Chur			Queen		
neral	5. Social Security I		Sex 1 M 2 F		s. last birthday, Yrs.	Months 1	Days	If Under Hours		8. Date of Birth (Month, Day May 4,	Year)	9. Birthp	place (State or Foreign of the lington DC
ector	228-58 Usual Residence		X	52	110.					May 4,	1947	wasn	ington DC
10	10a. State	10b. County		10c. C	City, Town or L	ocation						1	0d. Inside City Limits
uneral Director	MD	Washir	ngton		Willian	nsport							1 ☐ Yes ※☐ No
i Director		10e. Street and Number 10807 Bower Avenue					217	95		1	10g. Citizen of What Country? USA		
Funeral	11. Marital Status		12. Was Dec	sedent Ever in	U,S. 13.	Was Decede	ent of H	lispanic Or	lgin? (Sp	ecify Yes or No-		ce - Americ	
E	1 Never Mar	ried 20 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert				Rican, etc.)	-	ck, White,		
by		4 Divorced	If Yes, G Year or I	ive ~~	- 10	1 ☐ Yes 2	No No	Specify:			Specif	y: Whi	.te
Completed	(000	15. Decedent's E	ducetion	,	16a. Dece	dent's Usual	Occup	ation	et of more	ina	16b. Kind of B	usiness/Inc	dustry
eldi	Elementery/Sec	ondery (0-12)		(1-4or 5+)		kind of work DO NOT use		d)	e or work	ing .			
Con			4		Co	onsult	ant						Susiness
To Be		17. Father's Name (First, Middle, Last) Charles A. Nauman								e (First, Middle, . Towsey	Ma <i>iden Sum</i> ar	ne)	
-		lame/Relationship				-				el Route Numbe Willian			
	20a. Method of Dis			20h	Placa of Disp			11110	1140,		20c. Location		
	1 DBurial 2	Cremation 3 5			cemetery, cre Ivy Hi	metory or oth	her plac	ry	1	2/21/99			ia, VA
important: If any injury or ance.	21. Signature of F	21. Signature of Fuheral Service Licensee					22. Name and Address of Facility Everly-Wheatley Funeral H Rd., Alexandria, VA					Home, 1500 W. B	
14	23a. Part1. Enter	the disease, or com art feilure. List only	plications that	caused the de	ath. Do not en						est,		Approximate Intervat Between
clan/Medical Examiner													
n/Medical	that initiated event resulting in death)	that initiated events resulting in death) Last Due to (or as a consequence of): d											
Physicia	Part II. Other aloni								1	23b. Did to	obacco usa co	ontributs to	o the cause of death?
y Physician		art is. Other arginites in Commissions contributing to death but not resulting in the underlying cause given in rait is.							1 ☐ Yes 2 No 3 ☐ Probably				
Completed by P										24a. Was a perfor	in autopsy med?	av	ere autopsy tindings ailable prior to impletion of cause death?
Com										1 🔯 Y	es 2 No	16	Yes 2□ No
Be	25. Wes case refe	rred to medicat						26. Plac	e of Deat	h (Check only or	10)		
To B	examiner?] No	Hospitel: 1 🗆	Inpatient 2	☐ ER/Outpatie	nt 3 DO	A Oth			ome 5 Resid	ence 8 K)Oti	her (Specil	w at scene
	27. Menner of Dea	ath 5 Pending	28a. Dete (Mor	of Injury oth, Day Year)	28b. Time of	ot 26	Bc. Injui	y at rk?		28d. Describe h	ow Injury occu	rred Su	biect
Certification:	3 X Suicide 4 ☐ Homlcide 6 ☐ Could not be determined 28e. Piece of Injury - At home, building, etc. (Specify)					Inknown			•	28f. Location (Street and Number or Rural Route Number City or Town, Stete) 1008 Rolfs Was Church Hill, Maryland.			olfs Warf R
edical Co	29a. Certifier (Check only	1☐ Certifying Pl	miner: On the b	pasis of examin	nowledge, deal	th occurred a	t the tir			and due to the d	ause(s) end m	anner as s	tated.
Medical Certification	29b. Signature and	d title of certifier	and mai	ner stated.	1	29c.	Licens	e number		29d. Date sign		ed (Month,	Day, Year)
	January 05, 30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)								05,	2000			
)	Stephen	Radentz,		se of death (It	m 23e) (Type		Penr	Stre	et,	Baltimo	re, Mai	rylan	d 21201
State strar	JAN 0 6		Sener.	Registrar's Sig		ushal							
	0 0	LUUU			KACIG	ESTA-							

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** 27, Philip G. Ostrander, Sr Dec 1999 4p.m. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2133 Southland Road Woodlawn Baltimore # Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 10 M 20 F Yrs. 215-18-3512 77 Director 07 10 1922 Md Usuel Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Md Baltimore Woodlawn 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? Nama 23a or 2133 Southland Road 21207 USA Funeral Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Tyes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 Yes 2 No Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Service Rep Independant Agent 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Earl Roy Ostrander, Sr Helen M. Jones 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Philip Ostrander, Jr/son 1924 Westchester Ave, Balto, Md. 21228 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetary, crematory or other place) 20c. Location - City or Town, State Date 1 □ Burial 2 □ Cremetion 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Woodlawn Cemetery 12/31 Baltimore, 21. Signature of Funerel Service Licent 22. Name and Address of Facility Sterling-Ashton-Schwab Funeral Home, Inc 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory agest. — Md shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final 2 Jean MCART disease or condition resulting in death) Examiner Due to (or as a consequence of): 000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieled events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of): signed by the at if be detached for Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2□ No 3 Probably 4 Unknown þ 24b. Were autopsy tindings evailable prior to Completed 24a. Was an eutopsy completion of causa of death? 1□Yes 2NNo 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury et Work? After 5 Pending investigation 1 Naturel death. 1 Yes 2 No 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. Medical 29a. Cartifier completely

altimore, Maryland 21215-0020

Box 68760,

P.O.

Records,

of Vital Physician:

Division or Attending

Hospital

To the ş

-DHMH 16 Rev 6/95

Day. State 2000 Registrar

(Check only one)

29b. Signature and title of certifier

IMAN 5400 32. Registrar's Signature

30. Name and address of person who poppleted cause of death (Item 23a) (Type, Print)

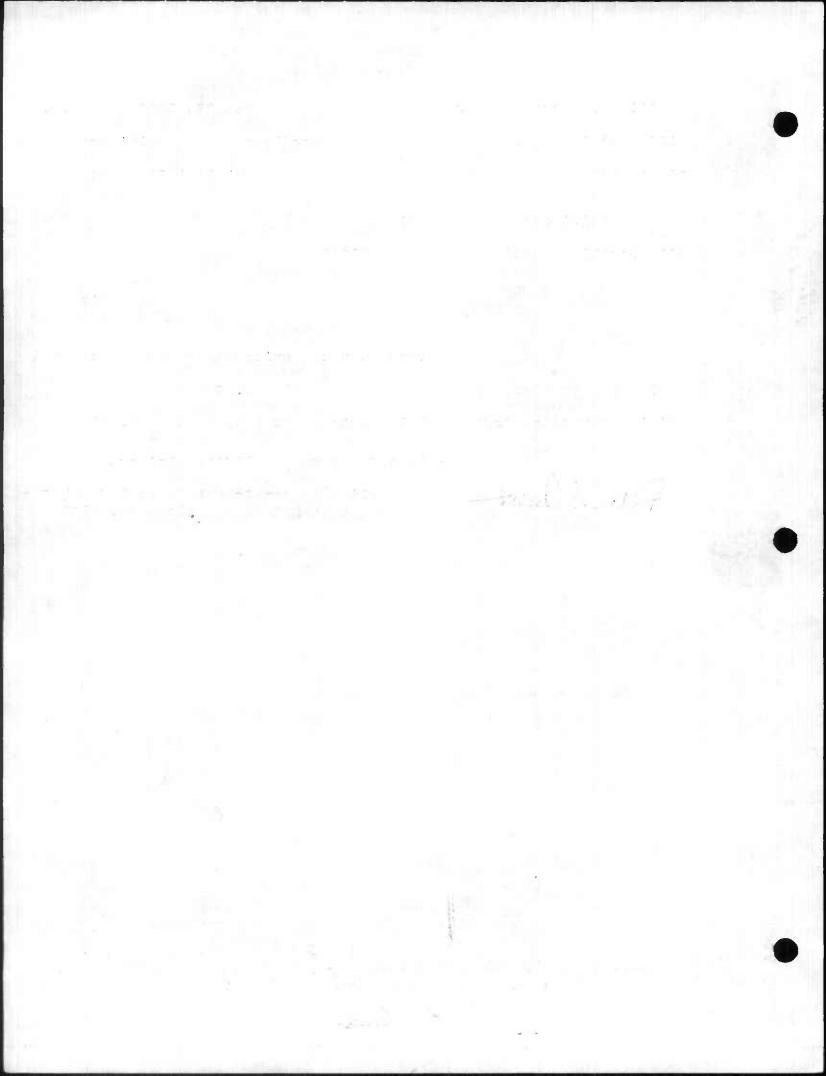
224

29c. License number

Court Rd #204

MD 21133

29d. Date signed (Month, Day, Year)



99-7925-005

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

22 1223	003						
FREDRIC				State	of N	Maryla	nd / <u>Departm</u> 28 <i>Certific</i>
TIMPICE	ABATERITO	TOPMO	1100	DADO	-	0.7	000
OSHRY	AMEND	TIEMS:	# 23	PART	Ι,	2/,	28 Certification

d / Department of Health and Mental Hygiene 28 Certificate of Death Reg. No.

2000	WR. 9	La l	12
Reg. No.			

OSI	HRY AT
•	Physiciar /Medica Examine
	Funeral

with the Manyland

death

filed within 72 hours after

Maryland 21215-0020

Baltimore,

1. Decedent's Name (First, Middle, Last) FREDRIC

7. Age (In yrs. last birthdey)

Yrs 31

OWINGS MILLS

10c. City, Town or Location

2. Date of Death Month DECEMBER

8. Date of Birth (Month, Dey, JUL 8,

3. Time of Death 11:41A.M

10d. Inside City Limits

SOLOMON

Approximate Intarval Batween Onset and Deeth

1 ☐ Yes 2 No

4a Facility Name (If not institution, give street end number) 14 HARDEN AVE

OSHRY 4b. City, Town, or Location of Deeth

Hours

If Under 1 Yeer | If Under 24 Hrs.

Deys

10f. Zip Coda

OWING MILLS

Min

31, 1999 4c. County of Deeth BALTIMORE

10g. Citizen of What Country?

U.S.A.

Director

or 28a-f show

234

5

natural

Hygiena.

Pagas 1 and 2 should be nant of Haalth and Mental ant: If Itam 27 is marked o

other

the Medical Examiner must be notified at

Funeral

þ

Completed

5. Social Security Number 10a. Stete MD Directo

214-06-1987 Usual Residence of Decedent 10b. County BALTIMORE 10e. Street and Number 14 HARDEN AVENUE 11. Meritel Stetus 1 Never Married 2 ☐ Merried

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired)

College (1-4or 5+)

1 M 2 F

 Wes Decedant of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 ☐ Yes 2 No

21117

14. Race - American Indian, Black, Whita, atc. WHITE 16b. Kind of Businass/Industry

15. Decedent's Education (Specify only highest grade completed) Elemantary/Secondery (0-12)

FREDRIC

17. Fathar's Name (First, Middle, Last)

3 Widowed 4 Divorced

PTASCHEK, JR.

18. Mother's Neme (First, Middla, Maiden Sumeme) STEPHANIE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PETROLEUM STATION

19e. Informent's Neme/Reletionship (Type, Print) STEPHANIE BLOUNT / MOTHER

20b. Plece of Disposition (Name of cemetery, cremetory or other plece)

CASHIER

108 SPECTATOR LANE - OWINGS MILLS, MD 21117 20c. Location - City or Town, Stete

20e. Method of Disposition 1 X Kuriel 2 Cremetion 3 Removel from State 4 ☐ Donetion , 5 ☐ Other (Specify) 21. Signature of Junepal Service Local and

SHAAREI ZION CEMETERY

1/5/2000 ROSEDALE, MD

22. Name and Address of Fecility

SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208

Physician /Medical **Examiner**

The law requires that the death certificate be asscuted

or Attending Physician:

Box

P.O.

of Vital Records,

Division

Physician/Medical Examiner

þ

Completed

Be

2

Certification:

Medical

usa as the

attanding

aftar death.

Director: Aftar this cartificate has been signed by the a d in by tha funeral director, page 2 should be datached

permit. Page Department of Important: If any Injury or page.

Sequentielly list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest

Immediate Cause (Final disease or condition resulting in deeth)

NARCOTIC INTOXICATION

Dua to (or as e consequence of):

ir the diseese, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, been failure. List only one cause on each line.

Due to (or es e consequence of)

Due to (or es e consequence of):

Pert II. Other significant conditions contributing to death but not rasulting in the undarlying ceuse given in Pert I

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en eutopsy performed?

24b. Wera autopsy findings eveilable prior to completion of ceuse of daath?

2□No 26. Pleca of Deeth (Check only ona)

1 Yes 2 No

25. Was cese ratarred to medicat 1 XYes 2 No

27. Mannar of Death 5 Pending investigation

6 ACould not be

2 ER/Outpetient 3 DOA

AT HOME

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

SUBJECT INGESTED DRUGS Location (Street end Number or Rural Route Number, City or Town, Stata) 14 HARDEN AVE

MILLS, MD OWINGS 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar statad.

29b. Signeture end title of certifier

1 Naturel

2 Accidant

3 Suicide

29a. Certifier

4 Homicide

Hospitel: 1 Inpatient

O.C.M.E.

29c. License number

29d. Date signed (Month, Dey, Year) JANUARY 1,2000

who completed cause of deeth (tem 23a) (Type, Print) Mil

JACK 01/1 31. Date filed (Month, Day, Year)
JAN 0 6 2000

32, Registrar's Signeture

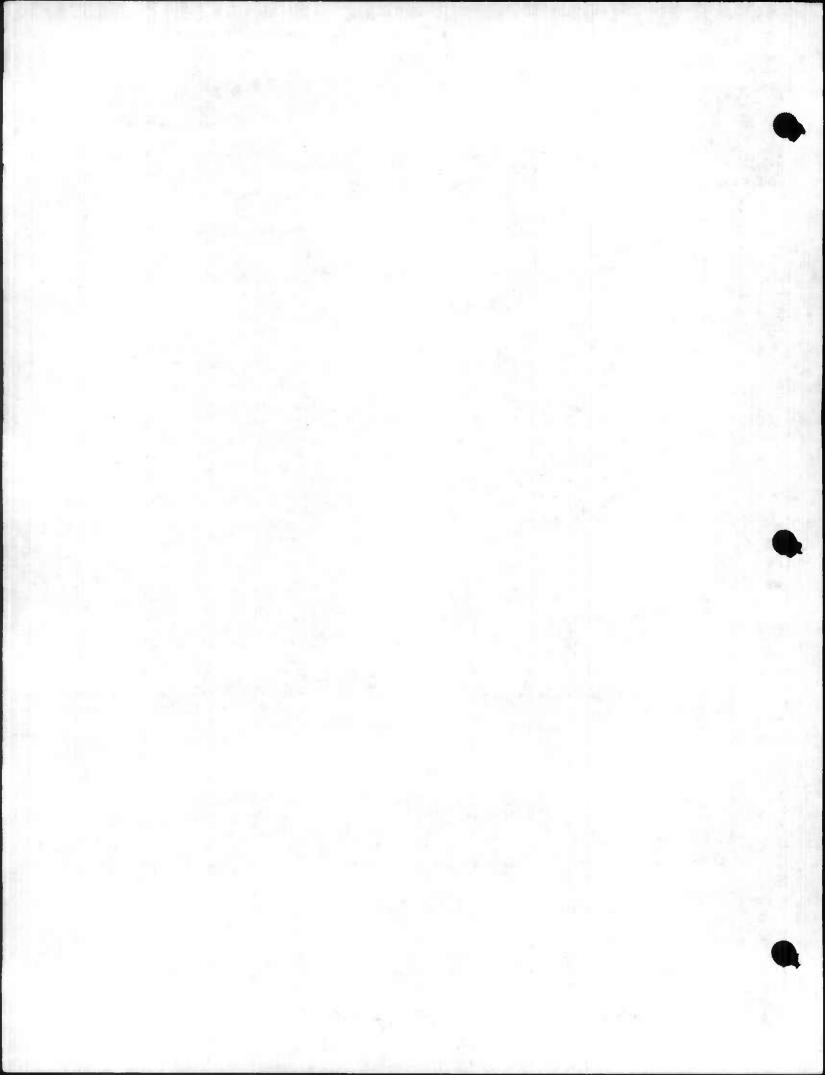
FOUND

111 Penn Street, Baltimore, Maryland 21201 Darks

State Registrar

complataly filled in by

To the Hospital within 24 hours a To the Funeral D

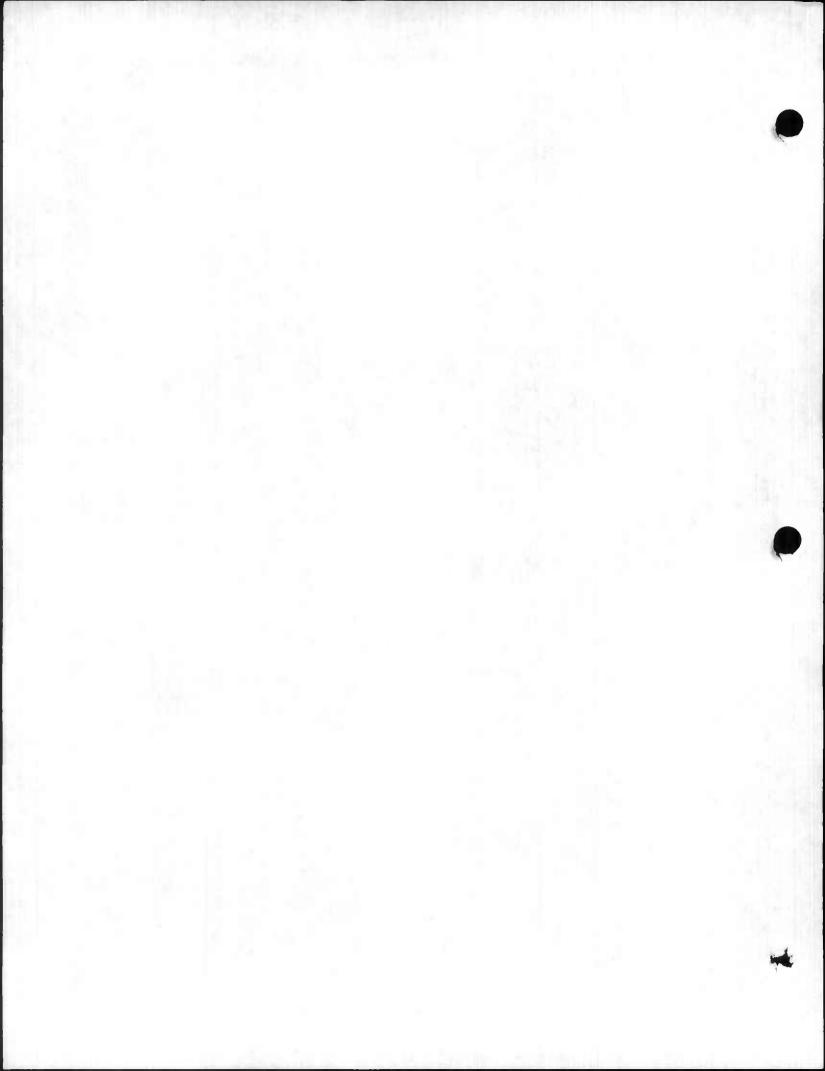


VOID
CERTIFICATE # 99-1/23

SEE

CERTIFICATE M

2000-CERTIFICATE
NUMBERED UNDER



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1.1721.

Physician
/Medical
Examiner

Funeral Director

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Beartment of Health and Mental hygians.

Experiment of Health and Mental hygians.

Important: If Itam 27 is marked other than "natural", or thems 23s or 28s-1 show any injury or other traumatic avent, the Medical Expriser must be noticed.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

1. Decedent's No			1.1.		ertifica	te of	Death		2. Data of Do	Reg. No.	Year		ima of Death
C'ha			reddic	K			Ih City To	wen or L	Decemb	xr 23	1999		1:45 PM
Jehns	Hepkin	on, give street and no	ew Me	dien	Laboratoria.	ter	Bull	hm		N/	nty of Death	י	
	2713	6. Sex 1 ★ 2 □ F	7. Age (In yrs. 75	last birthday Yrs.	Months	Days	If Under Hours	24 Hrs. Min.	8. Data of Bi	2.5°, 19	9. Birth 24	amten el	State or Foreign
Usual Rasidence	Sual Residence of Decedent Oa. Stata 10b. County 10c. City, Town or Location											10d. In:	sida City Limits
MD. N/A BALTIMORE													Yes 2□No
10e. Street and I		N STREET			10f. Zij	Code 2.1.2	224			10g. Citizen d		untry?	
11. Marital Statu	cedent Ever in U orces? 20 No ive	No			Decedent of Hispanic Origin? (Specify Yes or Ns, specify Cuban, Mexican, Puerto Rican, etc.) Yes 2 XNo Specify:								
	15. Deceder	nt's Education est grade completed		(Giv	edent's Usu re kind of wo	ork done	during mos	st of work	ing	16b. Kind of	Businass/l	ndustry	
Elementary/Se	econdary (0-12)		(1-4or 5+)	lifa.	RINTE	ise retired	1)			PAE	ER		
17. Father's Nam	na (First, Middle,	, Last)		,			18. Moth	er's Nam	a (First, Middle	, Meiden Sum	ame)		
FRANC	IS L. H	REDDICK					HE	LEN	MEYER				
19a. Informant's	Name/Relation	ship (Type, Print)		19b. Mai	iling Addres	s (Street	and Numb	er or Flur	al Routa Numb	ber, City or Tov	vn, Stata, Z	ip Code,)
IONA DI	EE SMIT	rh		342	2 S.	MAC	ON S	Γ.,	BALTI	MORE,	MD.	212	24
		3 □Removal from	State	Place of Disponentary, crit	emetory or o	other plac	-	RY 1	Date 2./2.7/	20c. Location Page 19 BAI			
Sequentially list if any, leading to cause. Enter Ur Cause (Disease that initiated eve resulting in death	or Injury	6	ven Due to (o	or as a conse	nlar	ar	inf			yocan	2:00	2	years
Part II. Other sig	nificant conditi	ons contributing to c	leath but not res	ulting in the	underlying o	ceuse giv	en in Part	1.	23b. Did	tobacco use	contribute	to the c	ause of death
									10	Yes 2 N	3 3 gr	obably	4 Unknov
					***	<u> </u>				s an autopsy ormed?	a	vailable	on of cause
									10	Yes 2 No	1	☐ Yas	20 No
25. Was case re axaminer? 1 \(\text{Yes} \) 2	larred to medica	Hospitel: 1	€npatient 2□	ER/Outpatie	ent 3 Di	OA Oth	or		h <i>(Check</i> only oma 5□ Res	one) idence 6 □0	Other (Spec	cifv)	
27. Manner of De 1 Natural 2 Accident	5 Pendii invasti	igation	of Injury nth, Day Year)	28b. Time Injury	of M	28c. Injur Wor 1 🔲	yat k? Yes 2□	No	28d. Describe	how injury occ	bernu		
3 ☐ Suicide 4 ☐ Homicid	6 Could determ	nined 288. Plac	e of Injury - At he ling, atc. (Specif	ome, farm, s y)	itreet, fector	y, office				(Street and Nu own, State)	mber or Au	ral Flout	a Number,
29a. Certifier (Check only one)	1 Certifyin	ng Physician: To the Examiner: On the band man	a best of my kno easis of axamina nner stated.	wledge, dea tion and/or i	nth occurred investigation	at the tin	ne, date an pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and date end place	manner es e, and dua	stated. to the c	ause(s)
29b. Signatura a	and title of certifie		Rem	ا کم	-	98	e number			29d. Date sig			
Stasia		Reynold	se of death (Item	uc !	Print) 49 46	Bal	hme	Ar	MD	211	24		

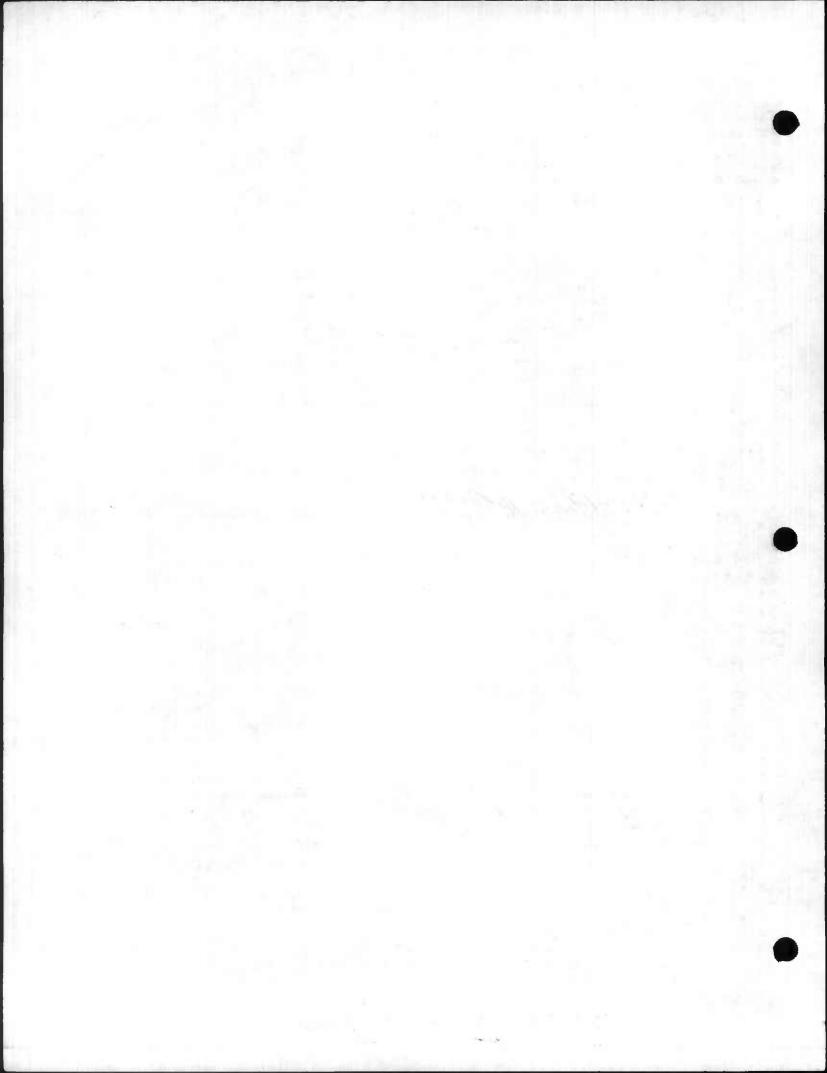
State Registrar

DHMH 16 Rev 6/95

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Sparks

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Aubrey DeVaughn Richardson 1999 10:25 AM 24 December 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Roland Park Place 830 W 40th Street Baltimore N/A 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 1⊠M 2□ F 244-20-5919 76 1923 N. Carolina March 7 Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland N/A Baltimore 10e. Sfreef and Number 10f. Zip Code 10c. Citizen of What Country? 830 W. 40th Street 21211 United States 12. Was Decedant Evar in U,S. Armed Forces? 1 2 Yes 2 No 196 If Yes, Giva 14. Race - American Indian, 11. Marifal Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) Black, Whifa, etc. 1 Never Married 2 Married 1944 1 ☐ Yas 2 X No Specify. 3 ☐ Widowed 4 ☑ Divorced 1946 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Physician Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Oscar Vaughn Richardson Katherine Edmond 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20400 Frederick Road Julia Rice (Daughter) # B-1 Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cherry Grove Bapt. Ch. Cemetery 1/7/00 Cherry Grove, NC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Bettle alever (. 6500 York Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior fo completion of cause of death? 24a. Was an autopsy performed? 2 0 No 1 Yes 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residenca 6 ☐ Other (Specify) 28d. Describe how injury occurred 28b. Time of

The law requires that the death certificate be executed Box 68760. tha signed by the at the detached for P.O. Division of Vital Records. page 2 certificata or Attending Physician: this After 24 hours after death.

Physician/Medical by Completed Be Medical Certification: To

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

Euneral

Director

28a-f

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Pages 1 and 2 should be filled within nent of Health and Mental Hygiene. ant: if item 27 is marked other then ury or other traumetic event, the Me

Physician

/Medical Examiner

the Marylan

filed within 72 hours after

Baltimore, Maryland 21215-0020

filled in by completely

25. Was case referred to medical examinar? 1 Yes 2 No 27. Manner of Death

29a. Certifier

(Check only one)

1 Naturat 2 Accident 3 Suicida 4 Homicide

5 Pending Investigation 6 Could not be determined 28e. Date of tnjury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner statad.

29b. Signature and fitle of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gregory Walker, M.D. 3333 N. Calvert Street Baltimore, Maryland 21218

31. Date tiled (Month, Day, Year)

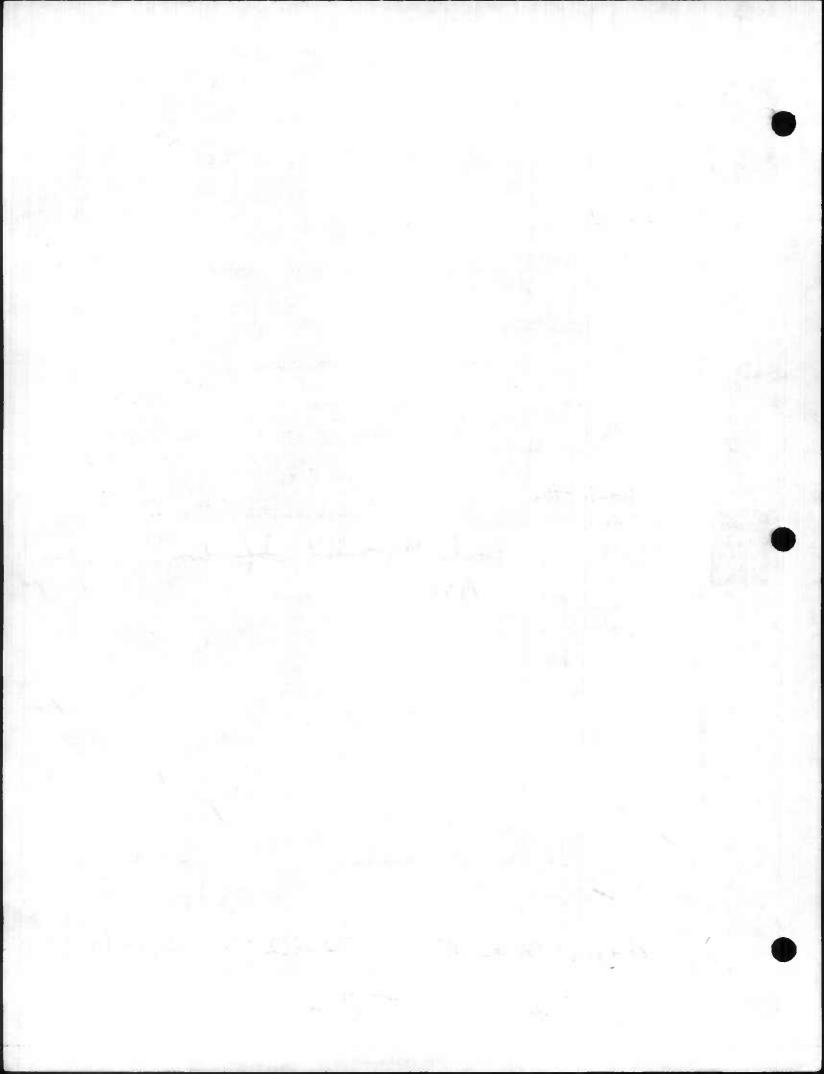
32. Registrar's Signatura IAN 062000

State Registrar

DHMH 16 Rev 6/95

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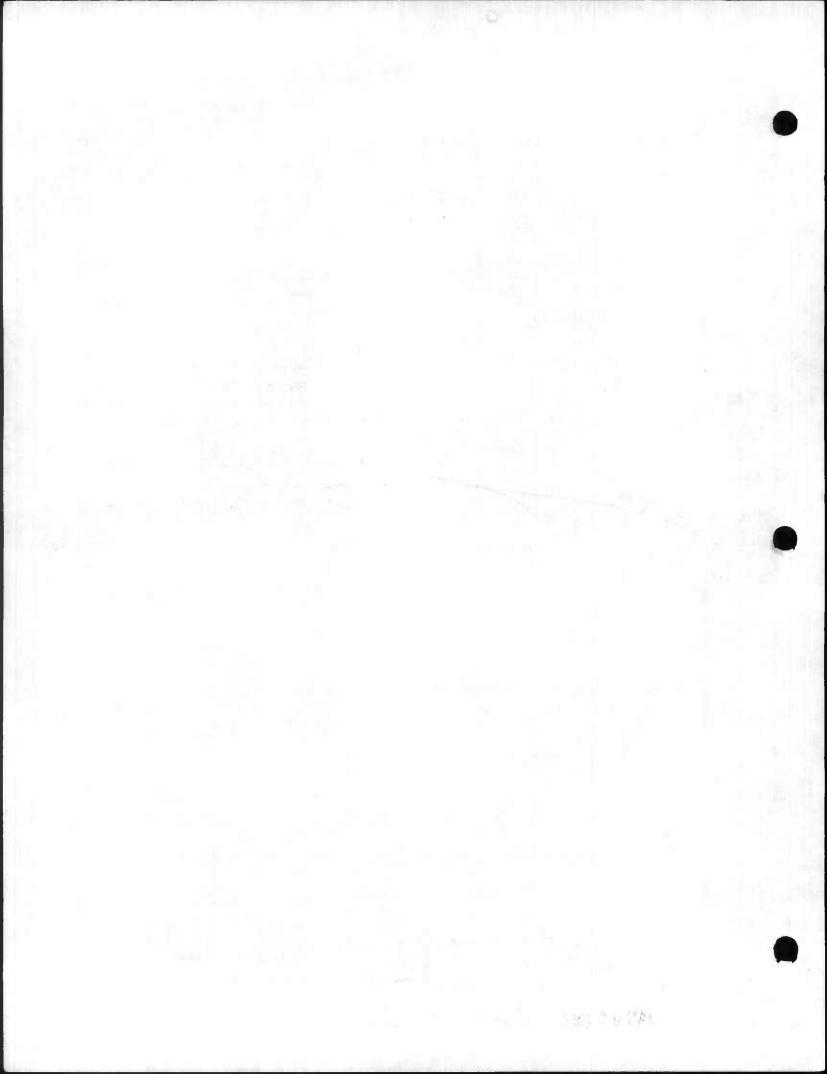


Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year DOROTHY BELL SINNOTT DECEMBER 31, 1999 9:25 AM /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Saint Joseph Medical Center Towson If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 20 F Director 213-09-9176 82 7/19/17 MARYLAND Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits "natural", or flams 23s or 28s-f show 1 Yes 2 No Director MD BALTIMORE TOWSON 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 305 E. JOPPA ROAD APT. 606 Funeral 21286 USA 14. Race - American Indien, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 静 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 🏋 ☐ No Specify: If Yes, Give Year or Dates: Specify. þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 8TH GRADE OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental is marked of JOHN HAYS CAROLINE JOHNSTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra SANDRA J. BUETTNER 908 STARBIT ROAD DAUGHTER TOWSON, MD 21286 20b. Placa of Disposition (Neme of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 1/4/2000 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, _MD 21286 Process of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel 1 DAY PNEUMONIA diseese or condition resulting in death) Examiner Due to (or as a consequenca of) Examiner burial-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last pue Due to (or as a consequenca of) Box 68760 physician Physician/Medical the Due to (or as a consequence of) ettending | for use as P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown ISCHEMIC HEART DISEASE Records, à 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an eutopsy peed page 2 1 Yes 2 No 1 Yes 2 No certificate Division of Vital al or Attending Physician: To safter deeth.

N Director: After this certificated in by the funeral director, pa Be 25. Wes case referred to medical examiner? 28. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 15 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signeture end thle of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-31-99 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 FRANCIS KHOO, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 0 6 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#29d PER MD. G779 1-6-2000 J.A. 1. Decedent's Name (First, Middle, Last) 2. Date of Death DECEMBER 21, 1999 3:49 PM Physician Albert Anthony Stripeitis /Medical 4a Facility Name (M not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F 212-18-8014 Director August 7, 1918 Maryland Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits MD ₩ Yas 2 No 28a-f Director Baltimore Baltimore 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 5106 Westland Blvd. Barne 23a United States 21227 Funeral 11 Marital Status 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Black, Whita, atc. 1 Types 2 No If Yes, Give Year or Dates: 1945 1946 e flied within 72 hours after if Hygiene. other than "natural", or it vent, the Medical Exemin 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: à 3 ☑Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Coast Guard Welder Maryland 17 Father's Name /First Miridle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be sent of Health and Mental Antanas Stripeitis Tekla Tautaviciute 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) of Health of Item 27 is Walter Albert Balcunas/Nephew 5705 French Avenue, Sykesville, MD 21784-9012 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stela Date 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Loudon Park Cemetery 12/28/99 Baltimore, MD 4 Donation S Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Avenue

Baltimore, Maryland 21229

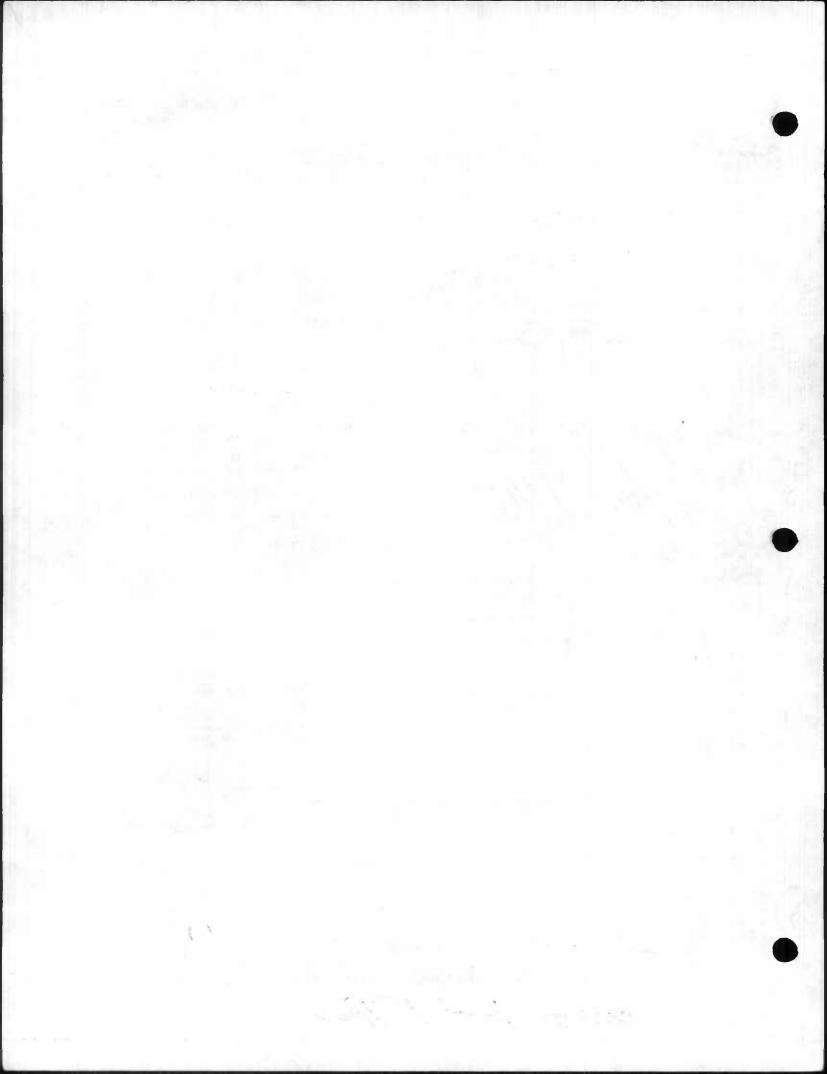
23a Park Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximete Intervel Between Onset and Deeth **Physician** ACUTE MYOCARDIAL INFARCTION Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner CARDIOGENIC SHOCK physician end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ISCHEMIC RIGHT FOOT Physician/Medical Due to (or es a consequence of): Box for use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 200No 1 ☐ Yes 20 No certificate 25. Was case referred to medical examiner? 88 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ž 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Atter 5 Pending investigation Attending 1 Yes 2 No 24 hours after death. 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stefe) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide à Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only within 2 To the F 2 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) D 18406 curum m 12-21-99 30 Name and address of person who completed cause of death (Item 23e) (Type, Print)
FRANK MORRIS, M. D., 7601 OSLER DRIVE, TOWSON, MD 21204

State Registrar

31. Date filed (Month, Day, Year) JAN 0 6 2000 32. Registrar's Signature



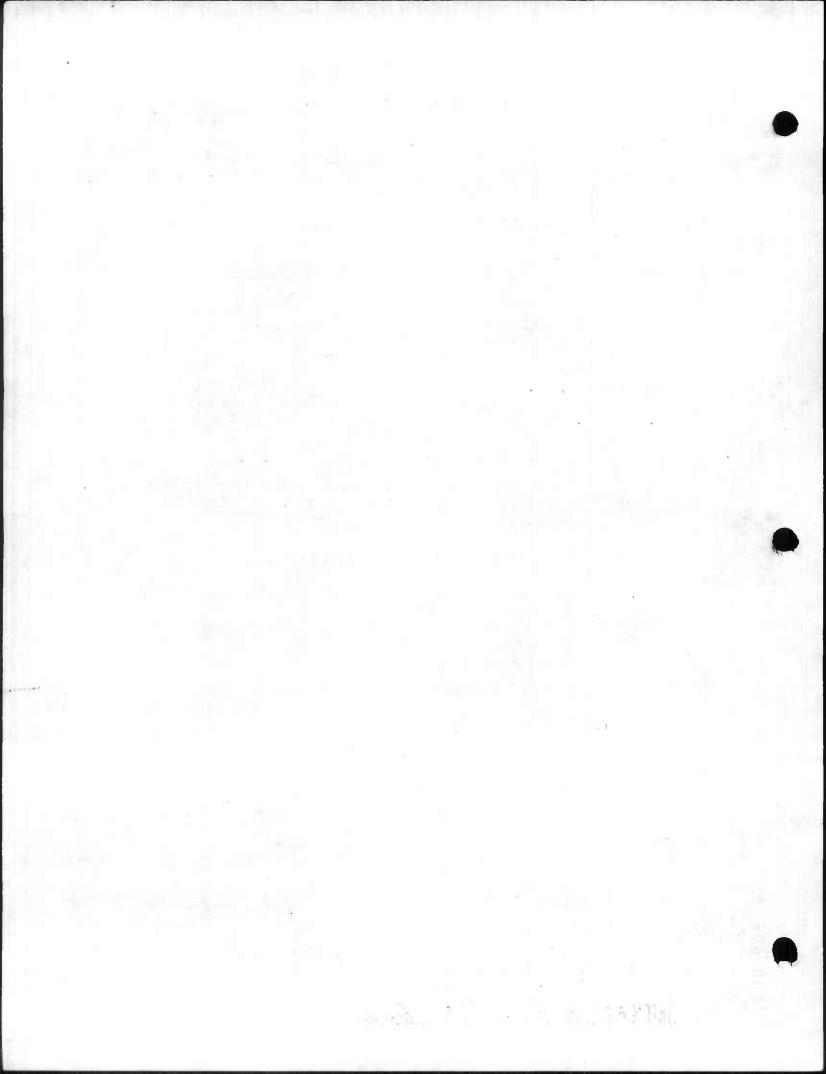
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Dev Year **Physician** 2:25 PM Mark Theodore Sutherin, Jr. December 31, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City N/A Johns Hopkins Bayview Medical Ctr. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1√ M 2□ F Yrs Director 60 22,1939 217-34-4467 Maryland Usual Residence of Decedent death with the Maryland ahow 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 3414 Wallford Drive 21222 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If New 27 is marked other than "natural", or New any Injury or other traumatic event, the Medical Examinat Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: P Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Police Sergeant Steel Industry aitimore, Maryland 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Mark Sutherin, Sr. Kathleen Kidwell 19a. Informant's Neme/Relationship (Type, Print) (Wife) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3414 Wallford Drive Dundalk, Maryland 21222 Mrs. Helen S. Sutherin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4,2000 Baltimore, Maryland 4□Donation 5x1Other (Specify) Entombmen Oak Lawn Cemetery Jan. 21. Signature of Funerel Service Licensee 22. Name and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Vessei Ather Scherchic Disease disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner sician and burial-transit Hypertension The law requires that the death certificate be assecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial Box 68760, mellitus Diobetes Physician/Medical Due to (or as a consequence of): 8 Hyperhonderna 080 signed by the at 3 be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Colon Cancul Records, þ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy page 2 s has certificate 1 Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ◯XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury Certification: 28d. Describe how injury occurred 28c. Injury et Work? After 5 Pending investigation 1 Netural 24 hours after death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital 29a, Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fl (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. the state 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 01-03-2000 047223 Karen min 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7141 Security BIVIL Bultmone mostory Kaven Piper Permanente m. Kaiser mo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

0 6-2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Douglas Kenwright Shiloh 10:07 AM 28, 1999 December 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Sociel Security Number If Under 1 Yaar If Undar 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) 1**X**M 2□ F Months Deys Hours Min 215-32-6210 Yrs 63 December 31,1935 Maryland Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 629 Bartlett Ave. 21218 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No if Yas, Give Year or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - Amarican Indien, Bleck, White, etc. 11. Marital Status 1 X Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced white 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Etementery/Secondery (0-12) College (1-4or 5+) 8 elderly care nursing home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Marion Raleigh Shiloh Kathleen Agnes Gandy 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Marjil McConnaughy/sister 2520 Linwood Rd. Baltimore, MD 21234 20a. Method of Disposition 20b. Pleca of Disposition (Name of camatery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremetion 3 ☐ Ramoval from State Greenmount Crematory 4 ☐ Donetion 5 ☐ Other (Specify) 12/29/99 Baltimore, Maryland 21. Signeture of Funeral Sarvica Licansee 22. Name and Address of Fedilit Mitchell-Wiedefeld Funeral Home, Inc 6500 York Rd. Baltimore, MD

It. Enter the disease, or complications that causad the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failura. List only one cause on each line. Approximete intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting In deeth) CongestivE HEART FAILURE CHRONIC OBSTRUCTIVE PUR MONARY DISEASE Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Last CENTS NEUMONIA Dua to (or es e consequenca of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 Unknown 24e. Wes en eutopsy performed? 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 2/2/No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Piece of Deeth (Check only one) exeminer? 200 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 Yes 2□ Accidant Investigetion 3 Suicide 6 Could not ba determined 28e. Plece of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

Examiner Records, P.O. Box 68760 Division of Vital

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 24 hours
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Physician

/Medical

Examiner

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Completed

Certification:

edical

29a. Certifier

Funeral

Director

r than "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at

the Maryland

death with

ges 1 and 2 should be filed within 72 hours efter it of Health end Mental Hygiene. If item 27 is marked other than "natural", or item

Peges nent of h 0

permit. Pege Department of Important: If any Injury or

Physician /Medical

other 1

Baltimore, Maryland 21215-0020

State Registrar

E 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Cheryl Dickason, M.D. 31. Dete filed (Month, Day, Yeer)

29b. Signature and title of contifier

32. Registrar's Signature JAN 062000

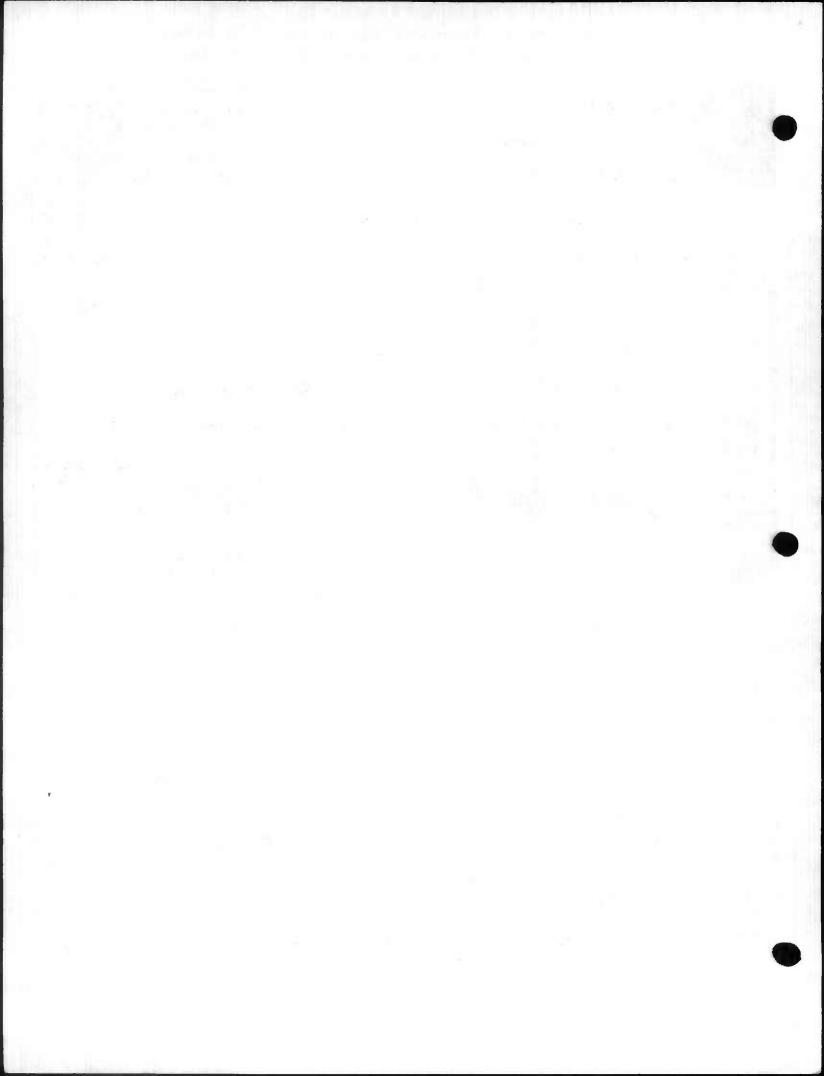
Union Memorial Hospital

🔀 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end menner es steted.

2 Medical Examiner: On the basis of examinetion end/or Investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner stated.

29c. License number

29d. Date signed (Month, Day, Yeer)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Susie Month **Physician** 8:55 A.M 3 December aylor /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Center Kasedale Baltimora If Under 24 Hrs. If Under 1 Year Birthplaca (Stete or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Days Hours Months 10 M 25 F 248-78-3630 56 S, C, Director -30-199 Usual Rasidance of Dacedent 10c. City, Town or Location r 28a-f show 10a. Stete 10b. County 10d. Inside City Limits ESSEX Ba 1 Yas 2 No Balto Director Md more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ma 23a or 2 Ser Court S.A. 21237 by Funeral 12. Was Decedent Evar in U,S. Armed Forces?

1 Yes 2 No Hyas, Give Yaar or Datas: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Peges 1 and 2 should be filed within 72 hours eiter di nent of Heelih and Mentel Hyglene. ant: if item 27 is marked other than "natural", or item ury or other traumatic event, ins Mendell Emitrian. Black, Whita, atc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specity: Black 3 ☐ Widowed 4 ☐ Divorced AVIOR, Susie Jane To Be Completed 16b. Kind of Business/Industry Spring Grove State 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elemantary/Şecondary (0-12) Collega (1-4or 5+) Hospital 12thqrade NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) Louis samue asser Dannie Welch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Balto Co 20b. Place of Disposition (Name of cemetery, crematory or other place) Court Taylor, Ir - Husband Mad homas 20a. Mathod of Disposition Date 20c. Location - City or Town, Stata Important: If it any injury or o 12 Buriel 2 Crametion 3 Ramoval from Steta permit. Pege Department o 4 □ Donation 5 □ Othar (Specify) -7-2000 Winas DOUTTSON Name and Address of Facility 21. Signatura of Funaral Sarvice Licensee prenue 300 Wabash 23a. Pert1. Enter the disaesa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** . System Inflammatory Response Syndrome with Hypotension Immediata Causa (Final disaasa or condition resulting in deeth) /Medical 2 Days **Examiner** Dua to (or as e consequence of): Adult Raspiratory Distress Syndrome Physician/Medical Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disaase or injury that Initiated avants Post Surgery for Unresectable Rectal Cancer ing physicien e Division of Vital Records, P.O. Box 68760, thet Initiated avants resulting in deeth) Lest Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown λq 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: 25. Was casa rafarred to medical exeminar? 26. Place of Deeth (Check only one) Hospital: 1 Inpatiant Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 2 ER/Outpatient 3 DOA this 28c. Injury et Work? 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of After 1 Natural 2 Accident 5 Panding efter death. Director: Af 1 ☐ Yes 2 No invastigetion 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Pleca of Injury - At homa, farm, street, fectory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital c within 24 hours of To the Funeral D completely filled 1 Certifying Phyelcien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, end due to the cause(s) and manner stated. 29a Cartifiar 29d. Data signed (Month, Day, Year) 29c. License number 29b. Signeture end titla of certifier December 31, 1999 RD 107854

Registrar DHMH 16 Rev 6/95

State

Driva

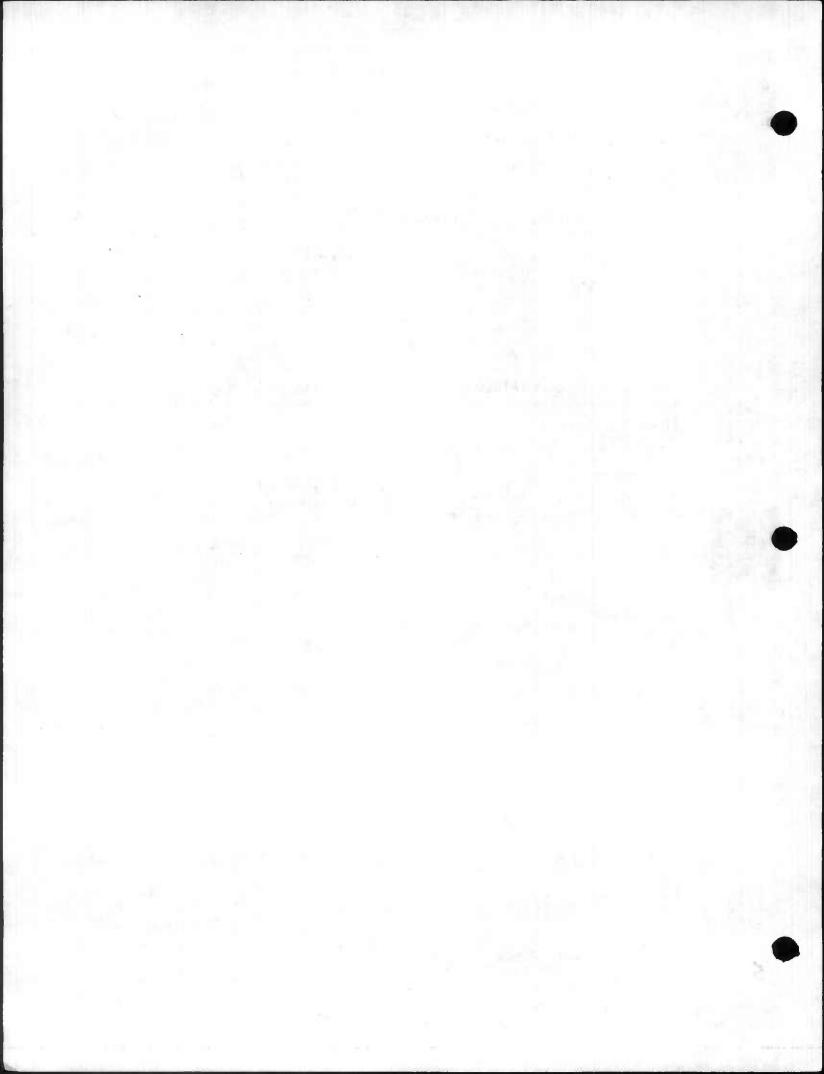
Baltimore, Maryland

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Marie Chatham, 9000 Franklin Square

32. Registrar's Signatura

Deneva

31. Dete filed (Month, Day, Year) JAN 0 6 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician 12 30 99 3:03PM Frederick Tanner /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Owings Mills Baltimore Co. 6 Leicester Ct If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** Days 74 M.D. Director 220-14-1232 11 **Usual Residence of Decedent** 10n State 10b. County 10c. City, Town or Location ra 23a or 28a-f ahow 10d. Inside City Limits 1 Yes 2 No Director Owings Mills Baltimore Co. MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21117 6 Leicester Ct. "netural", or Items 23s Funeral U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Capermit. Pages 1 and 2 should be filed within 72 hours after c Caperment of Health and Mental Hygiens. "Agrorant: if hem 27 is marked other than "natural", or her any injury or other treumatic event, the Hedical Francis Black, White, etc. 1 Never Married 2 Narried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: py 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Steel Bethlehem 9th grade Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 Rebecca Jackson Sterling Tanner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6 Leicester Ct, Owings Mills Md Thelma J. Tanner-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 Cremation 3 Removal from State Garrison Forest Vet 1/7/2000 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, Baltimore Md 21 Signature of Funeral Service Licenses la Warre 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ROSTATE CANCER

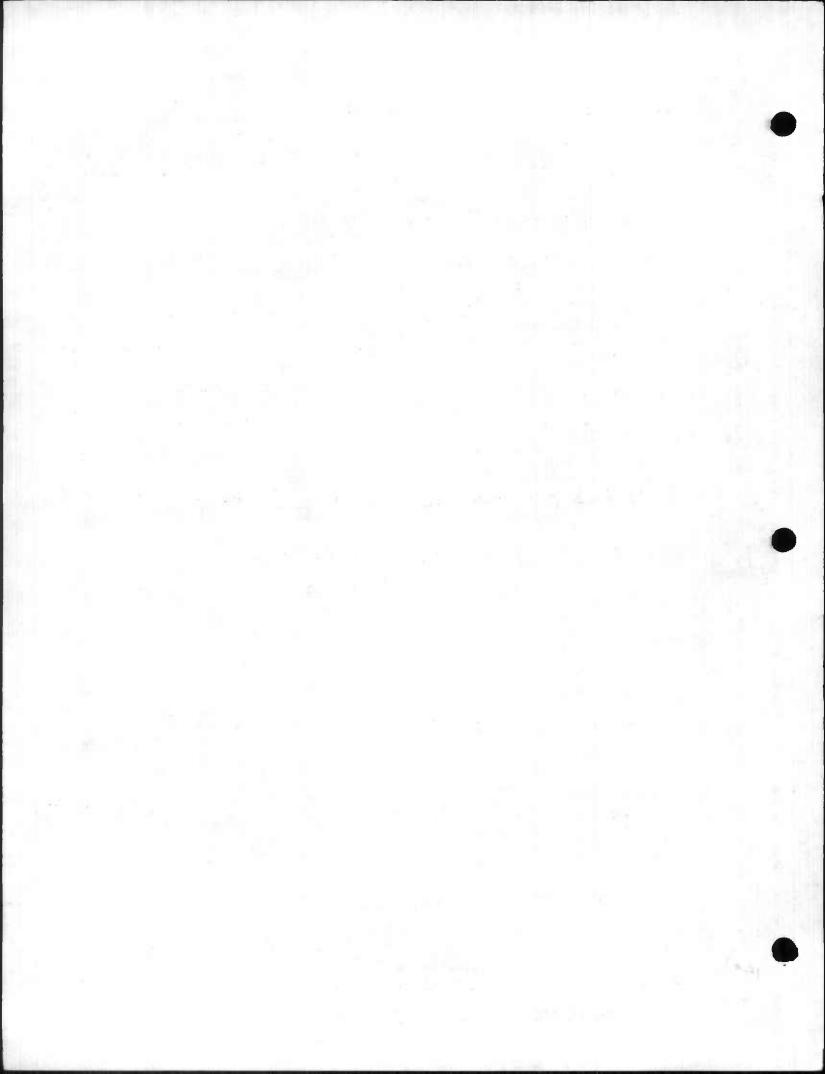
Due to (or as a consequence of): /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner BLEED ECTAL physicien end the burial-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 0 . Box 68760. Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Was en eutopsy performed? Completed page 2 s 1 Yes 2 No Division of Vitai Attending Physician: 25. Was case referred to medical examiner? B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Souther (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Magner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? in 24 hours effect death.

• Funeral Director: Affer stely filled in but. After 1 Netural
2 Accident 5 Pending 1 Yes 2 No investigation 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.

2 Nedical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29d. Dete signed (Month, Dey, Year) 29c. License numbe 184 1-3-2000 Jum (15+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #100, TOWSON MD 21204 RAYMOND A. NZE MD, 7801 YORLIC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 6 2000

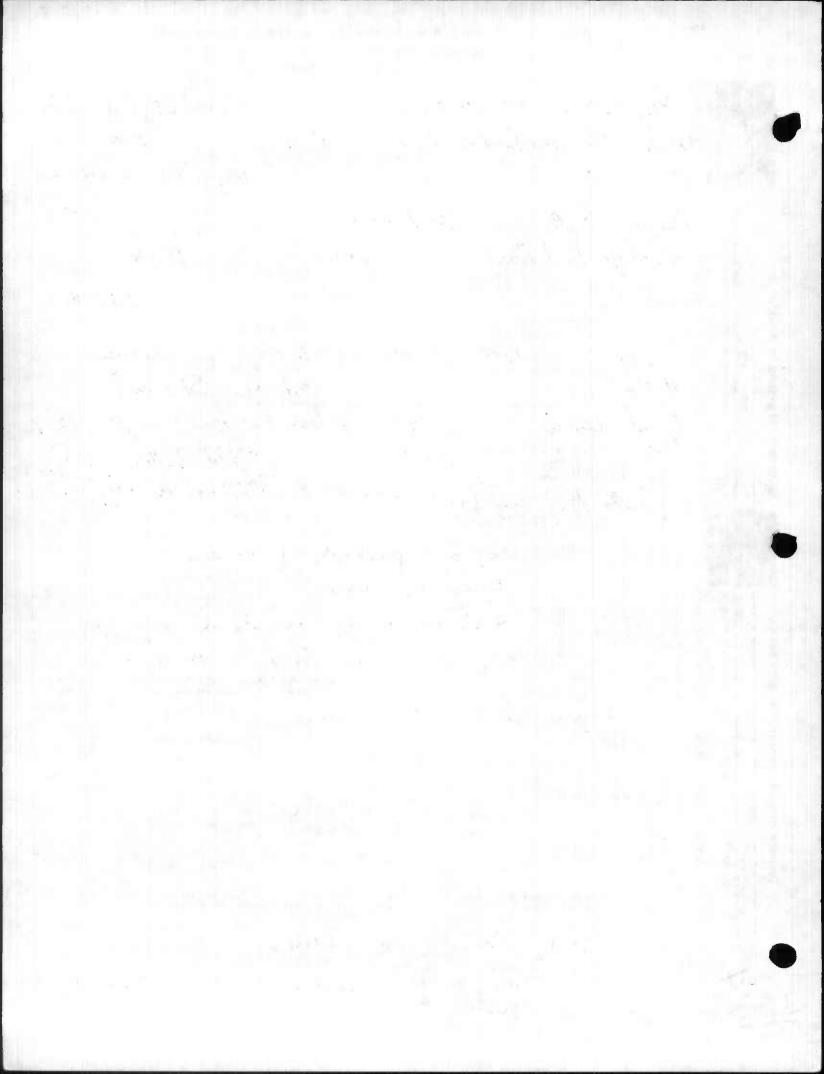
DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 200 **Physician** RAUhan ee December Sal PH /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end me 4c. County of Deeth Examiner Haborside Harto bardens 8. Date of Birth (Month, Dey, Yeer) Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) 10 M 20 F Months Deys Hours Min. 216-62-3210 Usuel Residence of Decedent Yrs may 16, 1912 Director with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28a-f show other traumatic event, the Medical Examinal must be notified at 1 Yes 2 No Maryland

10e. Street end Number Director 10f. Zip Code 10g. Citizen of Whet Country? 4700 Har 21219 SH Funeral 100d death 12. Was Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Rece - American Indien 11. Meritel Stetus Bleck, White, etc. 2 should be filed within 72 hours after and Mental Hygiena. Is marked other than "natural", or ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 Never Married 2 Married 1□ Yes 2⊟No altimore, Maryland 21215-0020 Specify: Specify: Black þ 3 ☑ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) ome maker tome 5+4 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) 2 04 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum page. reda 20c. Location / City or Town, Stete 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Date 20e. Method of Disposition Januara 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 2000 4 ☐ Donetion 5 ☐ Other (Specify) Funeral Berule a 22. Name end Address of Facility Douglass 21. Signature of Funeral Service Licenses 1201 Me Cullon Street, Baltimore, MC 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line. Approximete interval Between Onset end Deeth Physician Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Examiner Examiner attending physician and for use as the bunal-trans Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest ~ o Vasan Physician/Medical use as t 23b. Did tobacco use contributa to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed certificata has 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28e. Dete of Injury (Month, Dey Year) funeral 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury et Work? Certification: Hospital or Attending 11 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af 2 Accident 281. Location (Street end Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Plece of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Contifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner es steted. 29e. Certifier Medical completely 2 Medical Examiner: On the besis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier D31464 30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) SHOAIBA. HASHMI 921 N. Entow & fronte 308, Baltimore MD 21201 32. Registrer's Signeture 31. Dete filed (Month, Dey, Year) oaks. JAN 062000 Registrar



Please Type or Print in Biack indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month Dec. Physician Eloise Gregory Waller 26 8:00PM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Cheverly Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year)
DEC. 18 1931 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 10 M 20 F Days Hours 68 Yrs. Washington, D.C. 578-48-5561 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 No Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1249 Kenyon Street, N.W. Apt.#3 20010 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade comp 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry rade completed) College (1-4or 5+) Elementary/Secondary (0-12) Food Service Worker Private permit. Pages 1 and 2 should be file Department of Health and Mental Hyr Important: If fiem 27 is marked othe any Injury or other traumatic avant, place. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lynwood Gregory Eleanora Gregory 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Derrick Waller - Son 1303 Kingsheather Dr., Mitchellville, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removet from State 4 Donetion 5 Other (Specify) Harmony Memorial Cemetery 12/30/99 Landover, MD 22. Name and Address of Facility Latney's Funeral Home 21. Signature of Funeral Service Licenses CC0348 3831 Georgia Ave., NW Wash., DC 20011 Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finet disease or condition rasulting in death) METASTATIC COLON CANCER 1year Examiner Due to (or as a consequence of) SEPSIS 1 week Examine Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) RENAL FAILURE (ACUTE) 1-2 weeks Physician/Medical Dua to (or es a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes X☐ No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of tnjury (Month. Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Netural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide

sician and burial-transit that the deeth certificate be executed physician the burial Box 68760. P.O. Records. The law requires has page 2 Division of Vital after death.

Director: After this certifications funeral

the Maryland

"natural", or flams 23a or 28a-f show adreal Examiner must be notified at

should be filed within 72 hours after ond Mental Hygiene. marked other than "natural", or thei Imade avant, the Medical Examinan

traumatic avant,

Baltimore, Maryland 21215-0020

Certification:

Medical

in by filled 24 hours a To the Hosp within 24 ho To the Fune completely fi

Registrar

Hospital

30. Name and address of person who comp MARIO 31. Dete filed (Month, Day, State JAN 0 6 2000

29a. Certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) end menner stated:

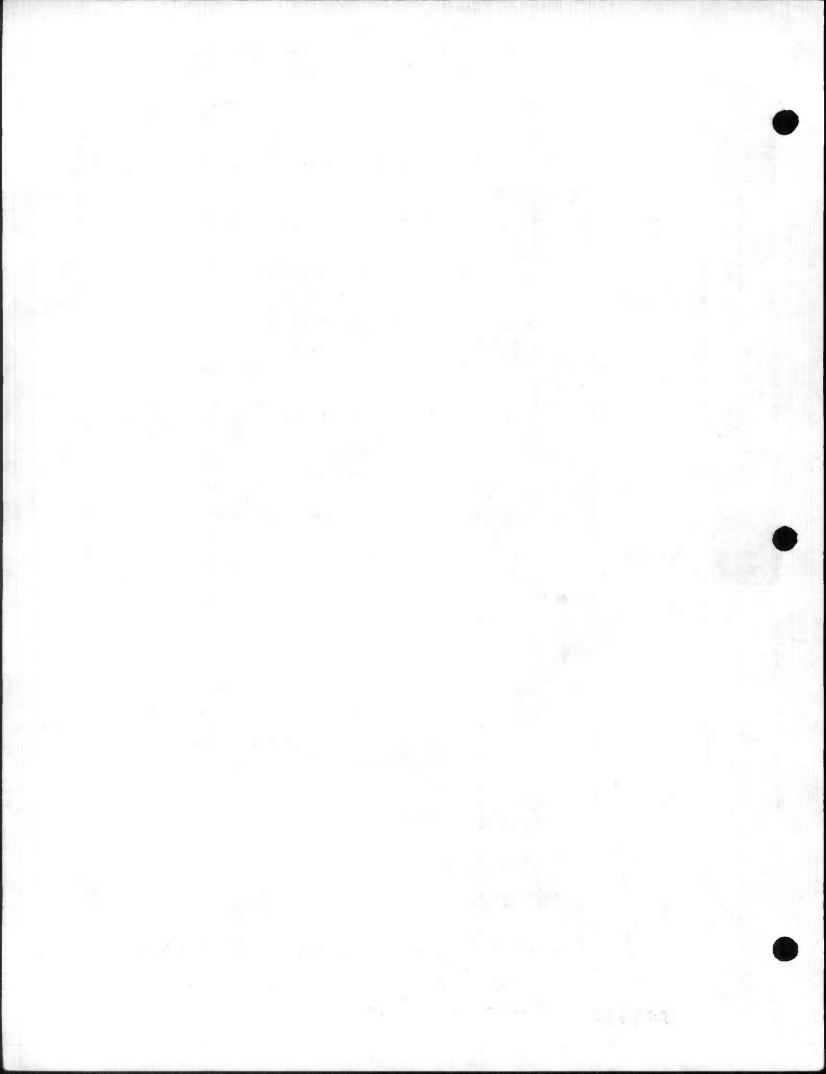
cause of death (ttem 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and menner as stated.

29c. License number

29d. Data signed (Month, Day, Year)

HOSPITAL PRIVE, CHEVERLY, MARYLAND 2073 M 3001 32. Registrer's Signeture



99-7048-51 SHERRELL _{AM}					41734				
Physician	Decedent's Neme (First, Middla, Last) SHERRELL ELIGENE WALKER		2. Date of Death Month	Day Year R 24, 1999	3. Time of Death 10:34P.M.				
/Medical Examiner	As Espille, Name (Mana Assaultation and a standard and assault and	4b. City, Tow	n, or Location of Death						
	GOOD SAMARITAN HOSPITAL		IMORE		BALTIMORE				
Funeral Director	5. Social Security Number 217-92-3383 G. Sax 1 M M 2 F 7. Age (In yrs. lest birthday) 35 Yrs. Usual Residence of Decedent	Months Days Hours	Min. 8. Date of Birth (Month, Day,) June 5,	8. Dete of Birth (Month, Day, Year) 9. Birthpl Count June 5, 1964 MARY					
ehow ed at	10a. Stete 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits				
e Mar	MARYLAND BALTIMORE BALTIMOR	E			1√ Yes 2□ No				
uth with the Ma 23a or 28a-fe unt be notified	10e. Street and Number 7106 HARFORD ROAD	101. Zip Code 21234	108	Citizen of What Cour USA	What Country?				
5-0020 72 hours after death with the Maryland natural", or flems 23e or 28e-f ehow diest Etember must be notified at each by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	Wes Decedent of Hispanic Origi Yes, specify Cuban, Mexican, I□Yes 2♥ No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Americ Bleck, White, Specify: BI					
The Part of the Land	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of DO NOT use retired)	of working 16	16b. Kind of Business/Indu					
faryland 2121 2 should be filed within and Mental Hygiene. Is marked other than 's aumatic event, the less To Be Comple	Elementery/Secondery (0-12) College (1-4or 5+) LABOR			CONSTRUCT	ON				
			s Name (First, Middle, Ma		VAI				
larylan 2 should be and Mental a marked o aumatic eve	SHERRELL EUGENE HENRY WALKER	SARA	H SERERANA S	SAVOY					
≥ p±2.5	DORN WALKER/SISTER 7106	g Address (Street and Number HARFORD ROAD,							
0 % 5 %	20a. Method of Disposition 1 ☐ Burial 2 ☼ Cramation 3 ☐ Removel from State	sition (Name of netory or other place)	Date 20	c. Location - City or To	wn, Stete				
Baltimore, permit. Pages 1 at Department of Hea Department of Hea Important: If flew 3 any injury or other once.	21. Signature of Funeral Service Licensee	FLECK FUNE G ROAD, LAUE	FLECK FUNERAL HOME, INC. ROAD, LAUREL, MARYLAND 20707						
Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heet failure. List only one cause on each line.								
/Medical Examiner	Immediate Ceusa (Final disease or condition resulting in deeth) a. UD DUOTIL TO Due to (or as e consequence)		1						
60, be executed clan and burtal-transit		uence of):		1					
P.O. Box 68760, at the death certificate be extended by the attending physician esched for use as the buria									
· 0 0 0 =	Part II. Other eignificant conditions contributing to death but not resulting in the ur	nderlying cause given in Pert I.	23b. Did tob	ecco use contribute t	o the cause of death?				
P.O. deteche			1 🗆 Yes	11	2 No 3 Probably 4 Unknown				
COrd requir should			24a. Was an autopsy performed?		ere autopsy findings allable prior to empletion of cause death?				
The law ate has page 2			15 Yes	2 No 1	Yes 2 No				
Vital Indelen: The certificate rector, pa	25. Wes case referred to medical axaminar?		Place of Death (Check only one)						
Of Vita Physicien: this certific ral director,	TO inpation 2 M Craodyalian		sing Home 5 Residen		(ע				
sion auth. or: Attente he fune	27. Menner of Death 1 Naturel 2 Accident 3 Suicide 5 Pending 1 Noticide 1 Noti	Work? 1 □ Yes 2 ☑ N	Yes 2 No UNKNOWN						
DIVI al or At a satier of in Diraci	4 Homicide 28e. Place of Injury - At home, ferm, strained building, etc. (Specify) FOUN		BALTIM	281. Location (Street and Number or Flural Route Number, RD BALTIMORE MD HARFORD RD					
DIVIS To the Hospital or Atti within 24 hours after de To the Funeral Direct completely filled in by t Medical Certific	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the companies of examination and/or inventor one) 1 Medical Examiner: On the basis of examination and/or inventor one)								
Toth Within	29b. Signeture end title of certifier Wattyre Pre Grull	29c. License number O.C.M.E.		1. Date signed (Month, OVEMBER 25					
Ø.	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 111 Penn Street	t, Baltimore	, Maryland	21201				
State	31. Date filed (Month, Dey, Year) 32. Registrar's Signeture	1 1							
Registrar	JAN 0 5 2000 Jenera 19	sporks							

ORIGINAL

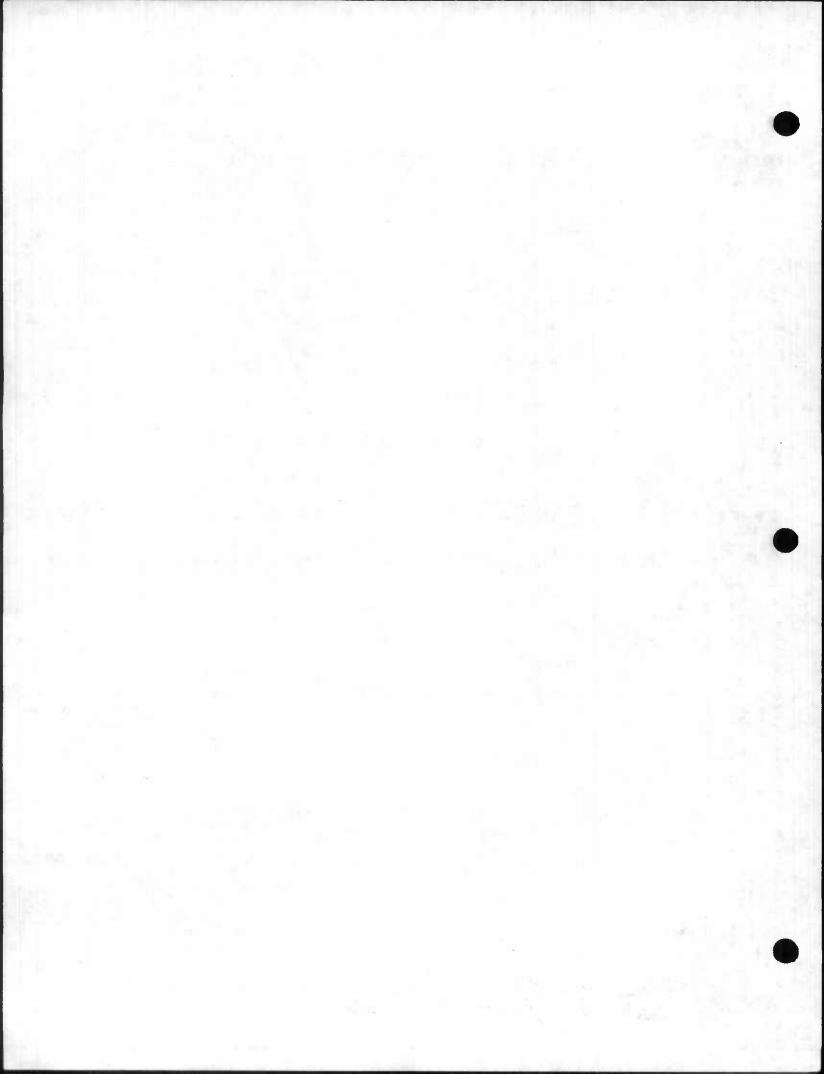
State of Maryland / Department of Health and Mental Hygiene QQ

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	1.	. Decedent's Nama (First, Middle, L	ast)						2. Data of Dea	ath		3. Tima of Death	Ī
Physician	_	Antionette	Y. Wh	itson					Month DECEMBI	ER 30,	1999	8:28 PM.	
/Medical Examiner	4.	a Facility Name (If not institution, g					4b. City, To	own, or Lo	cation of Death				
Lxammer	L.	JOHNS HOPKIN	S BAYVIEW	I			В	ALTIM	ORE		NA		
Funeral	5.			Age (In yrs. last i	birthday)	If Under 1 Ya		r 24 Hrs.	8. Date of Birtl (Month, Day	h	9. Birthp	laca (State or Foreign	7
Director		212-80-8410	1□M 2□F XX	40	Yrs.	Months Day	ys Hours	Min.	07-2	7. Year) 3-59		itry)	
	U	Isual Residence of Decedent	AA	40					0, 2	0 00	172	i D	-
deeth with the Meryland ms 23a or 28a-f show Linust be notified.	10	0a. Stata 10b. County		10c. City, To	own or Loc	ation					11	0d. Inside City Limits	Ī
the Meryla 28s-f sho northed se	5	MD Baltin	nore	Rane	dall	stown						1 ☐ Yes 2√ No	
28a-f	11	0e. Street and Number				10f. Zip Code	ð			10g. Citizen of	What Coun	itry?	-
0 4 0		26 Bishops Ga	a to										
manti manti	3 1	1. Marital Status	12. Was Deceder	nt Ever in U.S.	13 W	212		rigin? (Spe	city Yes or No-	USA 14. Bas	ce - Amaric	an Indian.	
r heme 23a or 28a-fa intermental birector	3	XXNever Married 2 Married	Armed Forces	s?				n, Puerto	ecity Yes or No- Rican, etc.)	Bla	ck, White,		
° % >		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		1	□Yas 2 1	lo Specify	7		Specif	y: B1	ack	
		15. Decedent's			Se Decede	ent's Usual Occ	cupation	-		16b. Kind of B			-
· # -		(Specify only highest g	rade completed)	10	(Give k	aind of work do	ne during mos	st of worki	ng	TOD. KING OF B	USING SWIN	lostry	
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vent.		7. Father's Name (First, Middle, La:	NA				19 Moth	er's Neme	(First, Middle,			. 50020	-
T is marked other traumatic event, To Be C													
marked matic e	-		nitson				Cla			obinso			_
T al	1	9a, Informant's Name/Relationship		1:					il Route Numbe				
item 27 other tr	L	Natasha Fre	eman					Cor	irt Rai				
2 8	20	0a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3	□Removal from Stat	come	of Dispos tery, crem	ition (Name of atory or other p	olace)		Date	20c. Location	- City or To	wn, State	
# >		4 □ Donation 5 □ Other (Spec		Vost					01-07-		Dund	alk,MD	
Departmen Important: any injury Diffe.	2	1. Signature of Funeral Service Lic	ansee		22.	Name and Add	dress of Facil	ity Ba]	timore	e, Mar	vlan	d 21202	_
eny ir		Bamala	0.6						01 E.				
	-	220 Part Enter the disease or on	KIMO	od the death. D	1						Ave	Approximate	-
	1	23a. Part1. Enter tha disease, or co shock, or heart failure. List on	one cause on each	line.	O HOL BING	i the mode of t	symig, soon as	s cardiac c	n respiratory ar	1631,		Interval Between Onset and Death	
iysician Medical		mmediate Cause /Final	11	0	1	0	1				1		
aminer	d	mmediate Cause (Finel lisease or condition esulting in death)	· HYPRITE	isive 40	Heroscus	profic C	Ardicuas	CULAM	- Visers	e		YEARS	
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in and ial-transit			b								1	17.4	
tran	S	Sequentially list conditions,		Due to (or as	a consequ	ence of):							ı
		sequentially list conditions, any, leading to immediate ause. Enter Underlying lause (Disease or injury hat initiated avents											
physician and is the burial-transit edical Examir	t	hat initiated avents asulting in death) Last	С.	Due to (or as	a consequ	ence of):	-				i		_
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d by the attender to the detached for us	P	art II. Other significant conditions	contributing to death	but not resulting	in the un	dariving cause	niven in Part	1.	23b. Dld t	obacco uee co	ontribute to	the cause of death'	?
tache tache		•							103	Yee 2 No	3 ☐ Prol	bably 4 Unknow	'n
signed by be detected by P									, ,	. 30 123 140		, Sincipal	
ed bl									24a. Was	an autopsy	24b. We	ere eutopsy findings	ī
page 2 should									perfo	rmed?	av	allable prior to impletion of causa death?	
2 N 0									V			1	
rector, pag									1/20	res 2□No	1,9	Yes 2 No	
s certificate hadirector, page	2	5. Was case referred to medical examiner?						e of Death	(Check only o	ne)			_
		NOXYes 2□ No	Hospital: 1 Inpa		Outpatient	3LI DOM			me 5 Resid			у)	
After th funeral funeral	2	7. Manner of Death ↑ Natural 5 ☐ Pending	28a. Date of In (Month, E	jury Day Year) 28b	. Time of Injury	28c. In	njury et Vork?		28d. Describe h	now injury occu	rred		
ne fu		2 ☐ Accident investigati	on			M 1	Yes 2]No					
by the		3 ☐ Suicide 6 ☐ Could not determine	200. FIECE OF I	njury - At home, etc. (Specify)	farm, stre	at, factory, offic	ce		28f. Location (S City or Tox		ber or Rura	al Route Number,	
at Director: After t led in by the funera Certification:			oonding,	oto. (Opoony)									
al (hyelclan: To the bes										
To the Funeral Director: completely filled in by the Medical Certifical			miner: On the basis and manner:	of axamination									
To the Funeral Director: completely filled in by the Medical Certifical		9b. Signature and title of certifier				29c. Lica	anse number			29d. Data signe	ed (Month,	Day, Year)	i
- 0		· Om	1/1	5 00			O.C.M	.E.		DECEMBI	ER 31	, 1999	
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D	30	O. Nama and address of person wh	complated ceusa of							73-0	1001		
, ,		SHUK MI. TITU	עוואי.		renr	1 Stree	r, Bal	CIMOI	re, Mary	y Land 2	TZUI		
State	3	1. Data filed (Mooth Day Year)	32. Regis	strar's Signature	1	n. V. 1							

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Month Year 12 28 99 11:52PM Withers Samuel 4e Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Mercy Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Date of Birth (Month, Day, Year) 12-24-1911 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) Days Hours Months 1 Ø M 2 □ F 88 Yrs 217-07-1921 N.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yas 2 No N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 2512 W. Fairmount Avenue 21223 13. Was Decadent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - Amarican Indien, Black, Whita, atc. 1 ☐ Yes 2 ☐ No If Yas, Giva 1 Never Married 2 Married 1 ☐ Yas 2 No **Black** Specify: Specify: 3 Widowed 4 Divorced Year or Detes: 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Steamship Trade Elementary/Secondary (0-12) College (1-4or 5+) N/A Longshoreman 9th grade 17. Father's Nama (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surnama) Albert Withers Annie 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Willie Mae Withers - Wife 2512 W. Fairmount Avenue Baltimore, Md 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Crametion 3 □ Ramoval from State Woodlawn Cemetery 1-4-2000 Baltimore, Md 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility March F/H West 200 4300 Wabash Avenue Baltimore, Md 21215 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on each line. Approximata Intarval Batwaan Onset and Deeth Immediata Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or es e consequence of) Dua to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown disen 24b. Ware autopsy findings available prior to complation of causa of death? 24a. Was an eutopsy performed? 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only ona) Hospitel: 2 PNo Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2D ER/Outpatient 3 DOA 1 Inpatient 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Neturel

Examiner physician and the burial-transit The lew requires that the death certificate be assecuted Box 68760 Physician/Medical signed by the a P.O. Records, λq page 2 Division of Vital or Attending Physician: Be Medicai Certification: To this funeral After ne Hospital or Attending in 24 hours after death. he Funeral Director: Aft. pletely filled in by the fun

Physician

/Medical

Examiner

Funeral

Director

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must be notified at

"natural", or hama 23s or

permit. Pages 1 and 2 should be filed within 72 hours after a Designment of Health and Mental Hygiers. Thousaffer I frem 27 is marked other than "natural", or han any lighty or other traumatic event, the Medical and a Medical

Physician /Medical

Examine

Director

Funeral

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Completed

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To

Completed 2 ☐ Accident 3 Suicide

29a. Cartifier

(Check only one)

25. Was case referred to medical examinar? 27. Megner of De

5 Pending invastigation 6 Could not be determined

Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify)

1 Yes 2 No

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

1🛱 Certifying Physician: To tha best of my knowledge, deeth occurred et the tima, data and place, and due to the cause(s) and mennar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated.

29b. Signature and Iitla of certifian

JAN

29c. License number

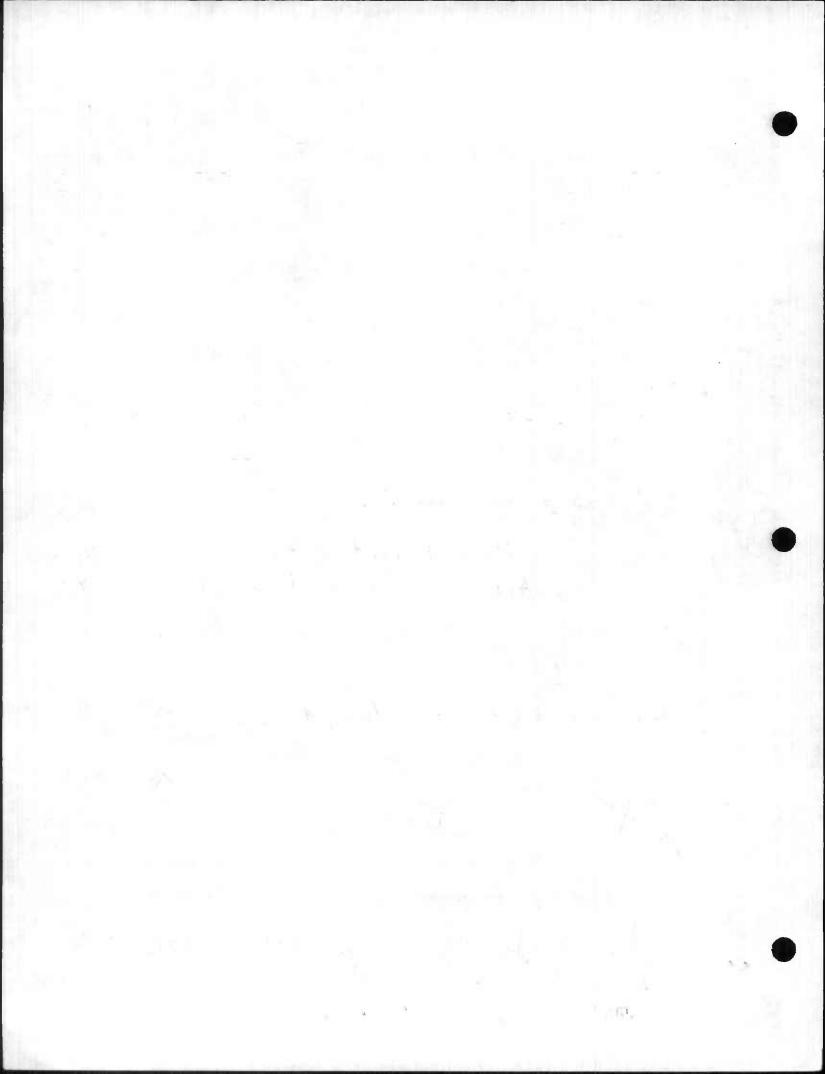
29d. Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) 30 20 9 rcuz 31. Dete filed (Month, Day, Y

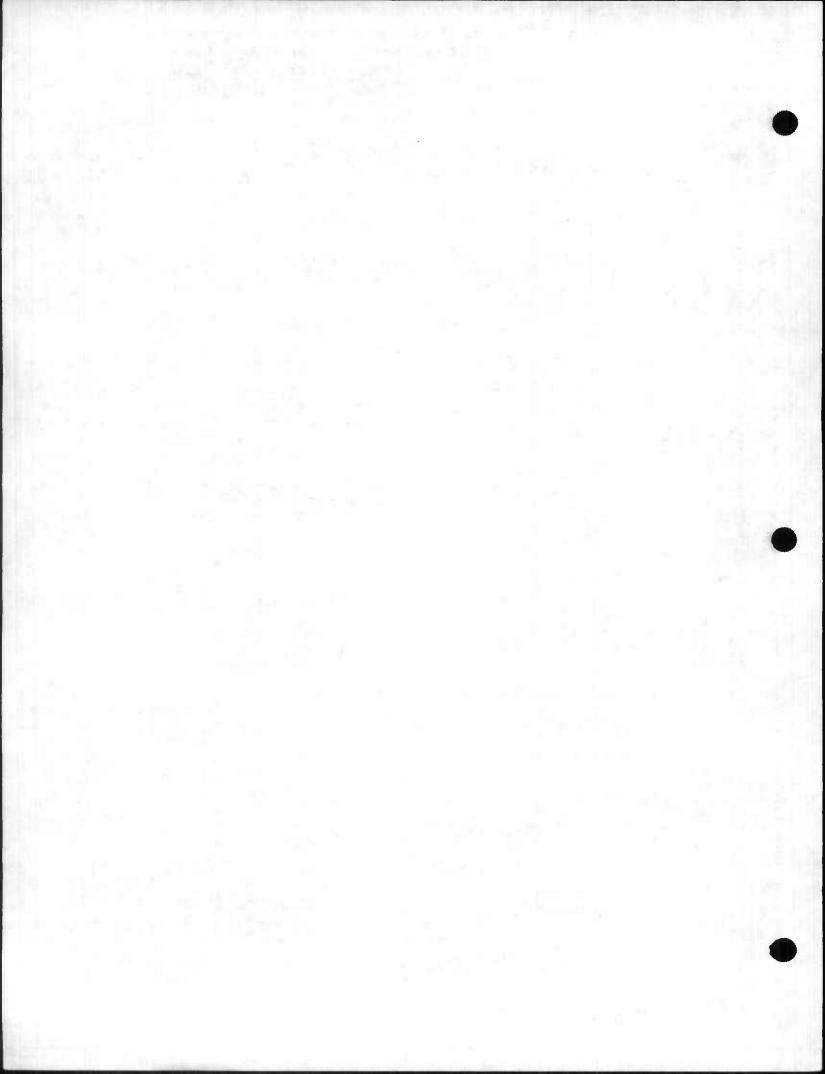
15 32. Registrar's Signatura

State Registrar

To the Hosp within 24 ho To the Fune completely fi



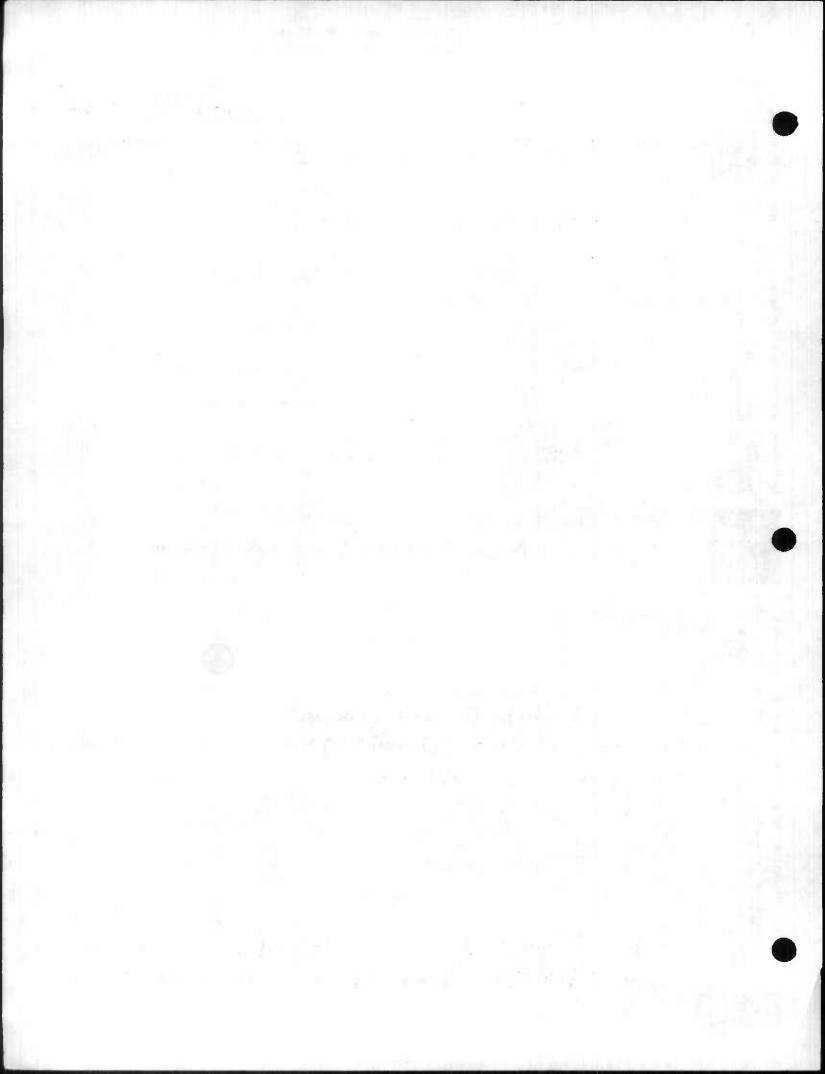
ysician	1. Decedent's N	ame (First, Middle, Las	st)			2. Date of De	Reg. No.	3. Time of Death
	T. Doodont o To	4	JAMES WILL	iAms		Month	Day Yes	er
Medical aminer	4a Facility Nam	e (If not institution, give		,,,,,,	4b. City, Town, or	December Location of Deat		99 10:12 A.M.
eral ctor		Baltimore y Number 6. Sc. 14-8759	Street, First 7. Age (In yrs.		Baltimon der 1 Year if Under 24 Hr. hs Days Hours Mir	s. 8. Date of Bir	y, Year)	Birthplace (State or Foreign Country) MD,
Inottlined at	10a. Stete	10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits
Director	MD	MA		B	ALTIMORE			1 □ Yes 2 □ No
Dis	10e. Street and			10f.	Zip Code		10g. Citizen of What	
Funeral	11. Marital Statu	E. BALTIN	12. Was Decedent Ever in U	S 13 Wes De	21202	Specify Yes or No	U.S.F.	merican Indian,
by Fun	1 Never M	arried 2 Married d 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		cedent of Hispenic Origin? (: specify Cuban, Mexican, Pue s 2 No Specify:	rto Rican, etc.)	Black, W Specify:	/hite, etc.
Completed	(5)	15. Decedent's Ed	de compieted)	16a. Decedent's U (Give kind of iife. DO NO	Isuel Occupation work done during most of wo T use retired)	orking	16b. Kind of Busine	ss/Industry
Com	Elementary/S	econdary (0-12)	College (1-4or 5+)	Cloud	REFINISHER		PURNIT	O IE E
o Be C	17. Fether's Ner	ne (First, Middle, Last) ARD A. U.	VILLIAMS S	R.		ome (First, Middle DRED C	Maiden Sumeme)	
-	19a. Informant's	Name/Relationship (7	Type, Print)		ress (Street and Number or F			
	MILDI	RED O'DEI	11 /0		AKECREST DR			,
		Disposition 2 Cremation 3 Con 5 Other (Specify	Removal from Stete	Placa of Disposition (cometery, crematory)	Neme of or other piece) HEAUEN	1/4/2000	SILVER S	
	21. Signature of	Funeral Service Lican	Il Macet	22. Name DELL 32.2	and Address of Facility A NOCE + SO S HICH ST	NS FUNG BALTIM	erac Hem	E 2/202
	23a Pairl Ent	er the disease, or comp heart failure. List only o	plications that caused the deet one cause on each line.	h. Do not enter the r	node of dying, such as cardi	ac or respiratory e	rrest,	Approximate Interval Between Onset and Deeth
r	Immediate Cau disease or cond resulting in deal	lition	a. Hanging Due to (c	or as a consequenca	of):			
ine		conditions,	b	or es e consequenca	of):		1	
хап	Sequentially list	o immediate =						
dical Examiner	Sequentially list if any, leading to cause. Enter U Cause (Disease that initiated ever resulting in deat	or injury	cDue to (c	or as a consequence	of):			
edical	thet initiated eve	or injury	cDue to (a	or as a consequence	of):			
Physician/Medical	thet initiated ever resulting in deat	or injury ents th) Last	cDue to (c d ontributing to death but not res					oute to the cause of death?
by Physician/Medical	thet initiated ever resulting in deat	or injury ents th) Last	d			1 🗆	Yes 2 No 3	Probably 4 Unknown 4b. Wera autopsy findings evailable prior to
by Physician/Medical	thet initiated ever resulting in deat	or injury ents th) Last	d			1 24a. Was perfi	Yes 2 No 3	Probably 4 Unknown 4b. Wera autopsy findings
Be Completed by Physician/Medical	Part II. Other sig	ants th) Last and the conditions of the conditio	d		ng cause given in Part I. 26. Piece of De	1 24a. Was perfi	an autopsy 24 prined? ection Yes 2X0 No	Probably 4 Unknown 4b. Wera autopsy findings evailable prior to completion of cause of death?
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Benito В. Batalla December 18 1999 8:05 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) March 12, 1918 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1₩ 2□F 81 Philippines Director 218-41-4960 Usual Residence of Deceden worle ! 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits e filed within 72 hours after deeth with the Maryle al Hygiene cother than contrast, or flems 23s or 28s-f show cother than castural, or flems 23s or 28s-f show vent, the Medical Express must be notified at 1 Yas 2 No Director Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2407 Sun Valley Circle 20906 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 41-46 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 21215-0020 Specify: Oriental 1 ☐ Yes 2 ☐ No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farmer Agriculture Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 end 2 should be fill ment of Health end Mental Hant: If Item 27 is marked off jury or other traumatic even Be Rufo Batalla Natalia Bañares 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beata Batalla / Wife 2407 Sun Valley Circle, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec, 27 20c. Location - City or Town, State tXXBurial 2 ☐ Cremetion 3 N Removel from State permit. Page Department of Important: If eny injury or page. Viloi Memorial Cemetery 1999 4 ☐ Donetion 5 ☐ Other (Specify) Bonot Legazpi City 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 1 RACHH 500 University Blvd. West, Silver Spring, MD20901 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Acute anterolateral Myccardial Infarction 3 days /Medical Immediate Causa (Finat disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burle Box 68760. Physician/Medical Due to (or as a consequence of): 88 for use signed by the e Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown edema Phlmonary þ 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed (Jumuna bular nectosis Rena certificate 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director. 25. Was case referred to medical axaminer?
1 ☐ Yes 2 No 8 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 24 hours efter deeth. 1 TYes 2 No **2** ☐ Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Con the basis of examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) \$ 29d. Date signed (Month, Day, Year) 0 Jackess December address of person who completed cause of death (Item 23a) (Type, Print) Or * 210 Silver Spring MO 3801 International bekee MD 31. Date filed (Month, Day, Year) DEC 2 0 32 Registrar's Signature State 1999 Registrar



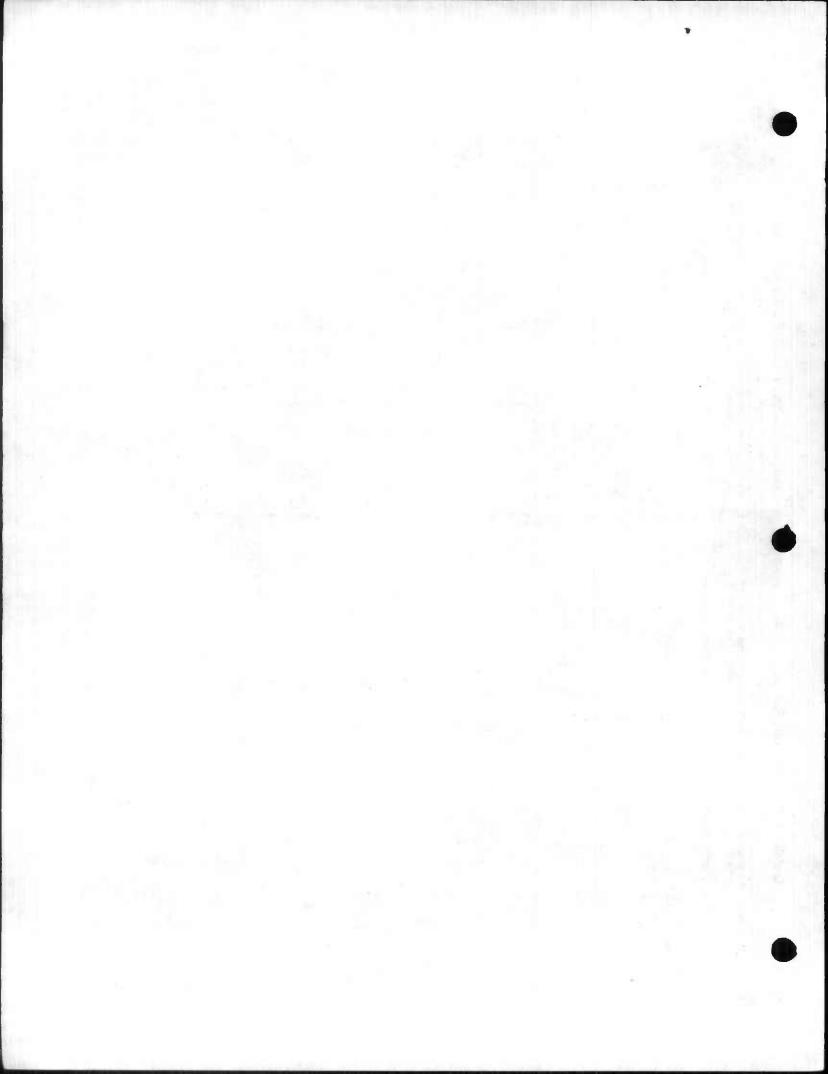
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

41739

			001	imodic of	Douth		Heg. No.		
Physician	Decedent's Name (First, Middle, Last Gray1		Bennett			2. Date of De Month Decembe	Day	Year 999	3. Time of Death 3:58 P.M.
/Medical Examiner	4a Facility Name (If not institution, give	street and number)		17	4b. City, Town, or	Location of Deat			
Funeral	SHADY GROVE 5. Social Security Number 6. S	ADVENTIST ox 7. Age (In y	HOSPIT	If Under 1 Year	ROCKV	LLE	MC	NTGO	
Director	219-76-0048 Usual Residence of Decedent	Ø м 2□ F 42	Yrs.	Months Days	Hours Min.	April (Month, Da	3, 1957	Misso	ce (State or Foreign y) Duri
aryan ahow dat	10a. State 10b. County		City, Town or Loc					100	d. Inside City Limits 1X Yes 2□ No
or 28a-f. be notified	Maryland Montgome:	ry Ga	ithersb	urg 10f. Zip Code			10g. Citizen of \	What Country	A SHIELD
23s or unit be				2087	8		United		
r harms 23st closes to the contract of the con	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13. V	Ves Decedent of Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puerl	pecify Yas or No o Rican, etc.)		e - Amaricar ck, White, et	
by Pres	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	1	☐ Yes 2 No	Specify:		Specify	Blac	k
of within 72 ho ygiens, meturn or then 'neturn t, the Medical	15. Decedent's Ed (Specify only highest gra	de completed)	(Give I	ent's Usual Occu kind of work done O NOT use retin	e during most of wo	king	16b. Kind of B	usiness/Indu	stry
d with d with giene.	Elementary/Secondary (0-12)	College (1-4or 5+)	Sa	les Man	ager		Retail	Store	е
be filed d other went, n					18. Mother's Nar	ne (First, Middle	, Maiden Sumen	10)	
Maryland 2 should be file th and Mental Hy 7 is marked oth traumatic event To Be (Joseph Stanley	Bennett	100		Audrey	Walker			
12 sh 12 sh 14 m	19a. Informant's Name/Relationship (7				et and Number or Ru				
- 5300	Susan M. Bennett		/ W1C		ce, Gaith	ersburg	, Maryla		
amit. Pages 1: Appartment of Ha mportant: If Item ny Injury or oth	1 M Burial 2 Cremetion 3 4 Donation 5 Other (Specify	Removal from State	cemetery, crem	eaven Ce	metery	Dec. 21, 1999			, Maryland
Depart Department Depa	21. Signature of Funeral Service Licen	meen Mood	Rol		ress of Facility umphrey Fun ntgomery Av				
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	d.	Arrhyth						Onset and Death
octificate be executed and the burlei-transit use as the burlei-transit and the delical Examiner		C	(or as a consequ						
		d	6.8						
of the deep d by the ette etteched for Physicia	Part II. Other algnificant conditions co	entributing to death but not i	resulting in the un	derlying cause g	iven in Pert I.	23b. Did	tobacco use co	ntribute to t	he cause of death?
		nomalies				10	Yea 2 No	3 Probe	bly 4K Unknow
h 2 90 Q							s an autopsy omed?	avail	e autopsy findings lable prior to pletion of causa sath?
= F # a O						10	Yes 2 No	10	Yes 2□ No
clen:	25. Was case referred to medical examiner?	Hospital:		- 10	26. Place of De				
를 들는 는	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2	☐ ER/Outpatient 28b. Time of	JAJ DOA	4LI Nursing F		how injury occur		
to or Attending Phis of Director: After the led in by the funeral Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year) Injury		Yes 2□No	28f. Location	(Street and Numl		Route Number,
To the Hospital or J within 24 hours effer To the Funerel Dira completely filled in b Medical Certi	4 nomicide	building, etc. (Spe		nocurred at the	time date and place		wn, Stete)	nnar se els	ted
To the Hospital of within 24 hours of To the Funeral D completely filled I completely filled I wedical Ce		mician: To the best of my life. On the basis of examination manner stated.	ination and/or inv	estigation, in my	opinion, death occu	rred at the time,	, date and place,	and due to t	he cause(s)
To the comp	29b. Signature and little of certifier			29c. Licer	nse number		29d. Date signe	d (Month, D	ay, Year)
15	Mele	parte	MMD.	D53	887		Decembe	r 17,	1999
	Orlee Panitch, M.	1			ve, Rockv	ille, Ma	aryland	20850	
State	31. Date filed (Month, Day, Year)	32. Registrar's Sig					,		

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Q Q 41740 Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12.17.1999 **Physician** 12:35 AM SUZANNE BENSADOUN /Medical 4a Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SILVER SPRING MONTGOMERY HOLY CROSS HOSPITAL If Under 24 Hrs. 8. Data of Birth 04.25.1934 Birthplace (State or Foreign Country) MORROCO 5. Social Security Number 7. Aga (In yrs. last birthday) If Under 1 Year **Funeral** Months Days Hours 1 M 2 XF 65 Yrs Director 219.78.2585 Usual Residence of Decedent the Manyland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show 1 ☐ Yes 2 ☐ No Directo GAITHERSBURG MD MONTGOMERY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or USA 20877 114 BILLINGS GATE LANE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 No WHITE ω Baltimore, Maryiand 21215-0020 1 ☐ Yes 2 X No Specify: Specify p 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry illed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CLOTHING SEAMSTRESS 12 Pages 1 and 2 should be filed tent of Health and Mental Hygient: If Itam 27 is marked other 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HABIBA OHAYON AMRAM OHAYON 2 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20877 114 BILLINGS GATE LANE GAITHERSBURG, MD ALBERT BENSADOUN/HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of Data 20c. Location - City or Town, State cemetery, cremetory or other plece) 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or price. PARDERS CHANAH CEMETERY 12.19.99 PARDERS CHANAH-ISRAEL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Eacity PUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haert failura. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) METESTATIC ADENOCARCINOMA Examiner Due to (or as a consequence of): Examiner E.COLI UROSEPSIS/BACTEREMIA physician and s the burial-trans Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in daath) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): attending p Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 94 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown ANASARCA, BILATERAL DEEP VENEOUS THROMBOSIS signed to Records, à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy Completed peeu hes pege 2 2 No 1 Yes 2 No certificate Division of Vital 25. Was case rafarrad to medical examiner? Be 26. Place of Death (Check only ona) Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 Yes 2 ₩ No this 27. Mannar of Death 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural Attending 5 Pending 1 | Yes 2 | No death. To the Hospital or Attendition within 24 hours after death.
To the Funeral Director: A completely filled in by the f Investigation 2 Accidant 6 Could not be datamined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Certifying Phyalcian: To tha best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and manner as stated.

Leading Phyalcian: To tha best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 298: Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/17/99 D34472 2 30. Name and eddress of person who completed cause of death (flow 23a) Type, Paint)

LYNNE DIGGS, MD 3170 BLADENSBURG RD, NW, WASHINGTON, DC

DHMH 16 Rev 6/95

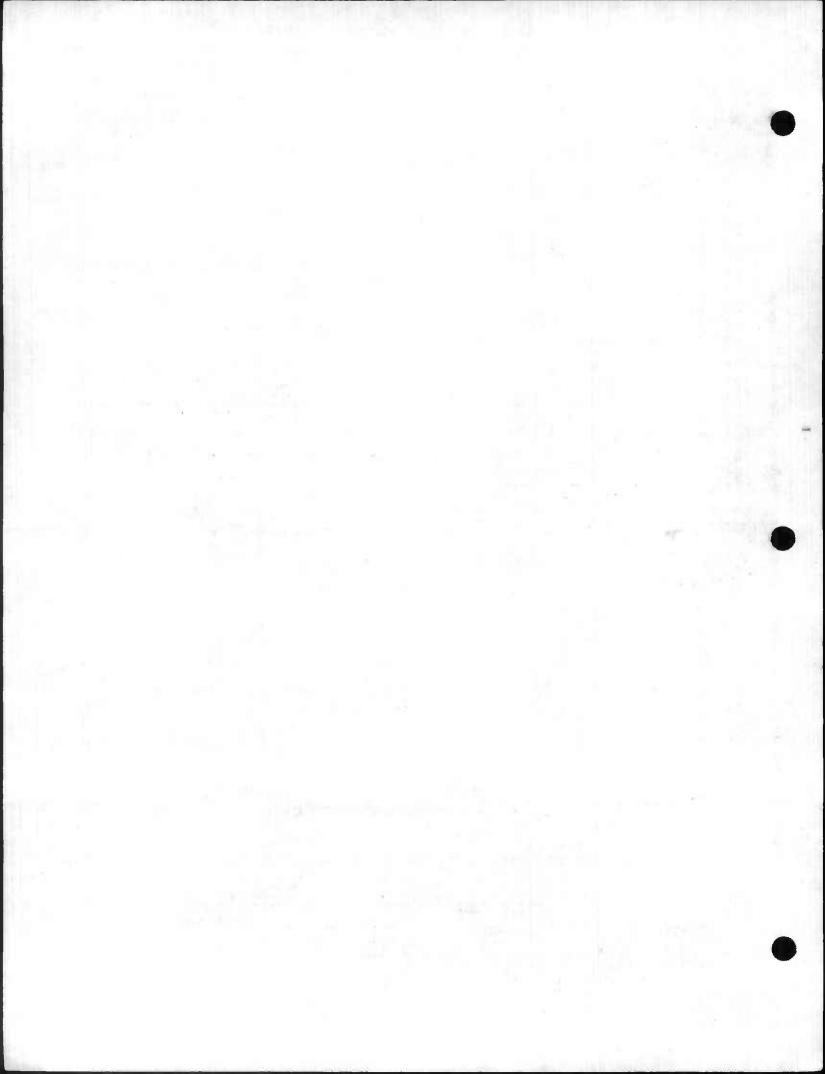
State

Registrar

31. Dete filed (Month, Day, Year)

DEC 20

32. Registrar's Signature



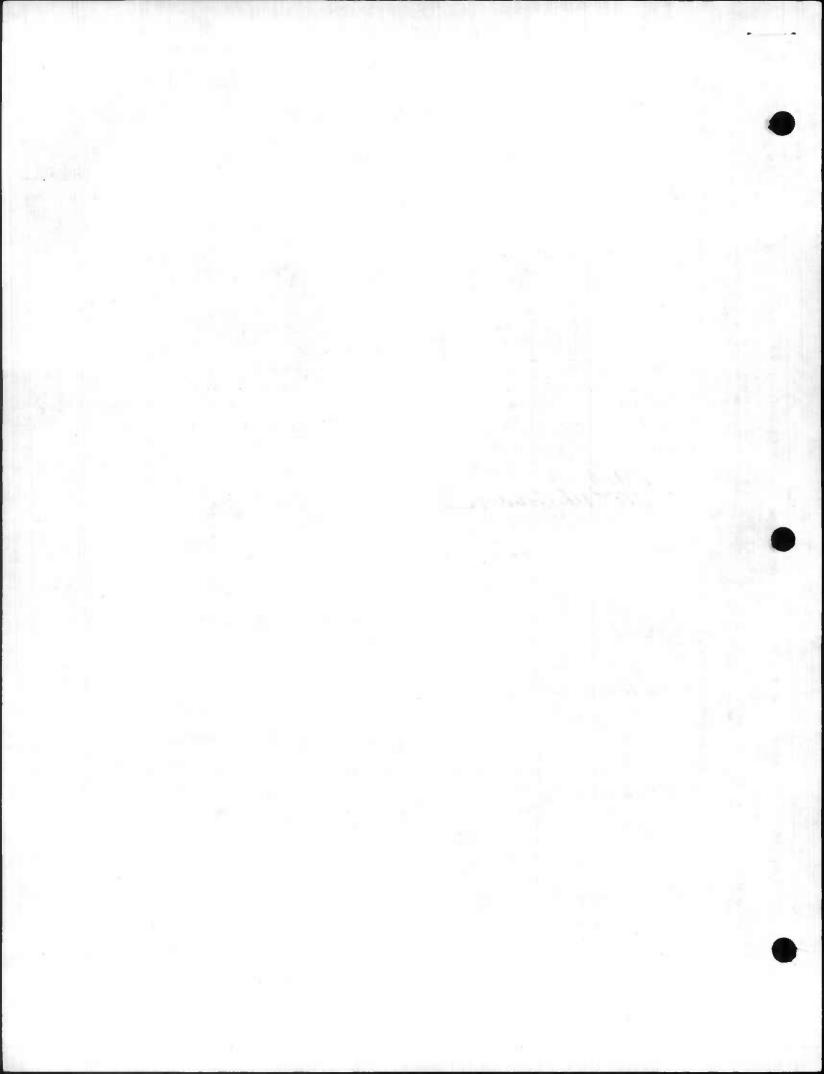
Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Day Year **Physician** 12 1:30 PM JOHN MARTIN BONESTEEL 13 99 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** Ocean City 11400 Coastal Highway Worcester Unit 7H H Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Deys 577-14-2696 12 M 2 F South Dakota Director 82 Usuel Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits ahow r than "natural", or itema 23a or 28a-f ahov the Medical Examiner must be notified at 1 XYes 2 No MD Worcester Director Ocean City 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 21842 11400 Coastal Highway Unit 7H USA Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. of 2 should be filed within 72 hours after the and Mental Hygiena.
77 is marked other than "natural", or the traumatic event, on Hedical Examinar 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yea 2 No Specify: Specify à 3 D€Widowed 4 Divorced Yeer or Detes: white Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Vice President Banking permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic eventions. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surname) Be Laura L. Schoenert Verne C. Bonesteel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 148 Anchorage Dr. S. Bethany Beach, DE 19930 Walter Ward - Personal Rep. 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 12/20/99 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA Arlington National Cemetery 21. Signature of Fyheral Service Licenses 22, Name and Address of Fecility Burbage Funeral Home 108 William St. Berlin, MD ed the death. Do not enter the mode of dying, auch as cardiec or respiretory errest, Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Examiner that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cerebral vaxulur disease physician the buna Box 68760. Physician/Medical USB 23b. Did tobacco use contribute to the cause of death? Pert ff. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. 1 1 108 2 No 3 Probably 4 ☐ Unknown signed t þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? Completed 1 ☐ Yes 2 1210 1 Yes 2 THO or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending 1 Yes 2 No 24 hours after death.

Funeral Director: A investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral D completely filled in Medicai 1 - Cartifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. (Check only onel 29d. Date signed (Month, Day, Year) 29c. License number D-44688 Dec 20 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) MD Salista V 10en 31. Date filed (Month, Day, 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

DEC 20



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** JAMES FRANCIS BOWDREN III DEC. 7, 1999 2:36 AM /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death **Examiner** SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY 5. Social Security Number 7. Aga (In vrs. last birthday) If Under 1 Yaar If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Data of Birth (Month, Day, Year) **Funeral** Days Months Hours 1**X** M 2□ F 21, 1943 MASSACHUSETTS 002-34-3785 Director 56 Usual Rasidenca of Dacedant the Maryland 10d. Inside City Limits 10e. Stata 10c. City. Town or Location 10b. County 28a-f show "natural", or items 23a or 28a-f show 1 ☐ Yas 2 No Director MD MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12019 GALENA ROAD 20852 U.S.A. Funeral death 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mertal thygiene. wit: if ferm 27 is marked other than "natural", or he my or other traumate event, in the leading in an iny or other traumate event, in 1 ☐ Yas 2 ▼ No If Yas, Give Yaar or Datas: 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: WHITE Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working lifa. DO NOT usa retired) Elementery/Secondery (0-12) College (1-4or 5+) General Services Administrator Government 18. Mother's Nama (First, Middle, Maiden Sumama) 17. Fathar's Name (First, Middla, Last) Be JAMES S. BOWDREN MARY McALOON 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau page. PENELOPE BOWDREN - WIFE 12019 GALENA ROAD, ROCKVILLE, MD. 20852 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Durial 2 Cremation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY 12/11/99 SILVER SPRING, MD. 21. Signature of Funaral Service Licenses 22. Name and Addrass of Facility Joseph Gawler's Sons, Inc. 3 5130 Wisconsin Ave., Washington, D.C. 20016 Combaker 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intarval Between Onset end Death **Physician** /Medical Immediata Cause (Final disaasa or condition rasulting in death) 6 YEARS MYELODYSPLASIA SYNDROM Examiner Dua to (or as e consequence of) Examine physician and s the burial-transit requires that the death certificate be axecuted Sequantially list conditions, if any, laeding to Immadiata cause. Enter Underlying Cause (Disaase or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 957 ed by the a Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. PO 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown DIABETES MELLITUS Records, þ 24a. Was an autopsy performed? 24b. Wara eutopsy findings available prior to Completed completion of cause of death? The law page 2 s 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: 25. Was casa referred to medical examinar? Be 26. Place of Death (Check only one) To Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1 Yes 2 No this funeral 27. Mannar of Death 28d. Describe how injury occurred 28h Time of Certification: 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 ☐ Pending 1 ☐ Yas 2 ☐ No death. Investigation 24 hours after death a Funeral Director: A pletaly filled in by the f 2 Accidant 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 | Homicida Hospital 1 🖄 Certifying Physician: To tha best of my knowledga, daeth occurred at tha tima, data and place, and dua to tha causa(s) end manner as stated. edical 29a. Cartifian within 24 hor To the Fune completaly fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, data and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and titla of certifian 29c. License number 29d. Date signed (Month, Day, Year) tulgami 023308 DEC. 11, 1999

State Registrar 9707 MEDICAL CENTER DR. ROCKVILLE, MD. 20850
32. Registra's Signatura

1. Socilal

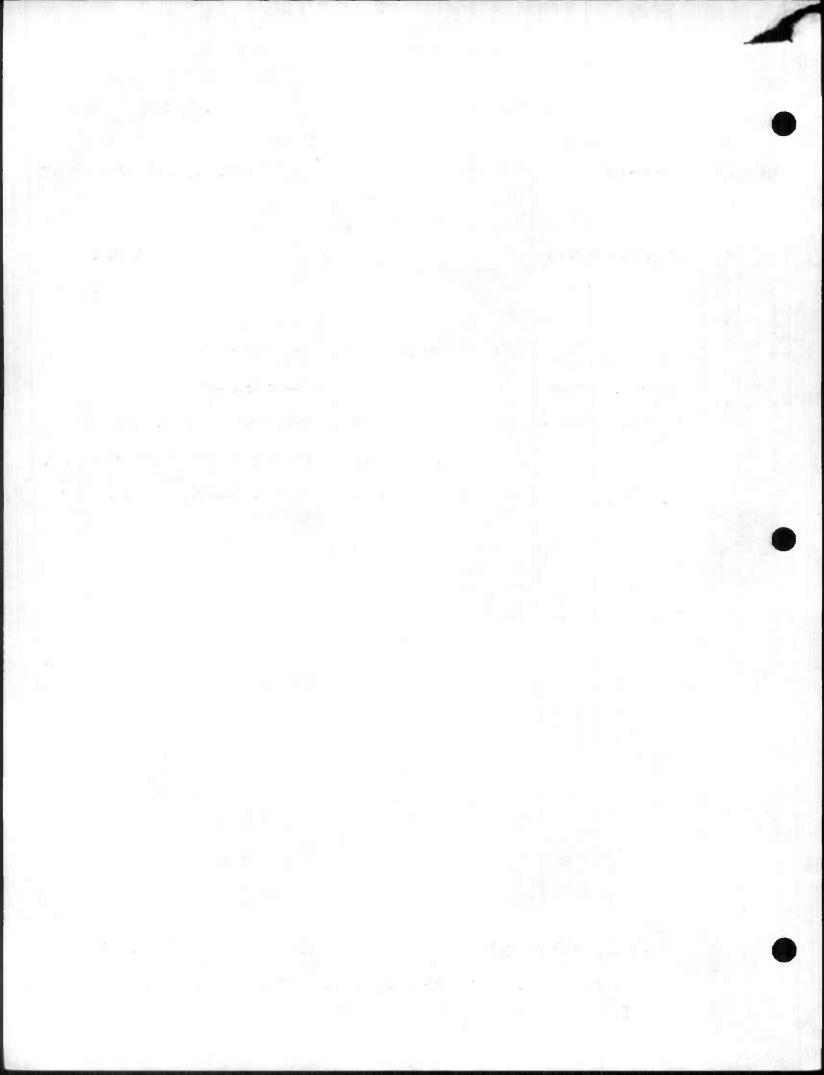
30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print)

MD.

VICTOR M. PRIEGO,

DEC 20

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Nama (First Middle Last) 2. Date of Daath December 9:108m Carl 1999 Braun 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva streat and number) Montgomery General Hospital 01ney Montgomery If Undar 1 Yaar | If Under 24 Hrs. 5. Sociel Sacurity Number 7. Age (In yrs. last birthday) 8. Deta of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1X) M 2 F 93 Yrs. 055-09-4162 April 14,1906 New York Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Insida City Limits N/A 1 Yes 2□No Washington, DC 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 4030 Chancery Ct., NW 20007 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 14∑ Yes 2 ☐ No If Yes, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Naver Married 2 Merried 1 Yes 2 No Specify: Specify: White 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) Elementery/Secondery (0-12) College (1-4or 5+) Pharmaceuticals Salesman 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fathar's Name (First, Middle, Last) Edward Michael Braun Mary Schneider 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charles R. Braun/ Son 4030 Chancery Ct., NW, Washington, DC 20007 20b. Plece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Dec. 20. 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removel from State Olney, MD Judean Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) 1999 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Danzansky-Goldberg Memorial Chapels, Inc 1170 Rockville Pike, Rockville, MD 20852 23a. Pert1. Enter the diseasa, or complications that causad the heath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Ceuse (Final disease or condition resulting in death) Due to (or es a consequence of) Due to (or es e consequence of) Due to (or es e consequance of) 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Donknown CKE 24b. Were autopsy findings available prior to 24a. Was an autopsy

Physician /Medical Examiner

physicien and s the burial-transit

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the detached

been signed by

hes certificate

Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifical letaly filled in by the funeral director,

8

The law requires that the death certificate be axecuted

Records, P.O. Box 68760,

Division of Vital

Physician/Medical Examiner

by

Completed

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Certification:

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any ir

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow

Director

Funeral

þ

Completed

DC

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Exercitive must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health end Mantal Hygiena. Important: If tem 27 is marked other than "natural; or items 23 any injury or other traumatic event, in "Medical Facilities" man

Baltimore, Maryland 21215-0020

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Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Dementio 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one)

2 PER/Outpatient 3 DOA

28h Time of

1 Inpatient

28a. Date of tnjury (Month, Day Year)

completion of causa of deeth? 1 Yes 2 19 No 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Streef and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the besis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner steted.

29b. Signature and title of certified

1 ☐ Yes 2 No

27. Manner of Death

2 Accident

4 ☐ Homicide

(Check only one)

3 ☐ Sulcide

29a. Certifier

1 Naturel

29c. License number

28c. Injury at Work?

29d, Data signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

54223

1 ☐ Yes 2 ☐ No

State Registrar

2 1

completely

within 2

NGUYEN THUAN 31. Data filed (Month, Day, Year) DEC 20 1999

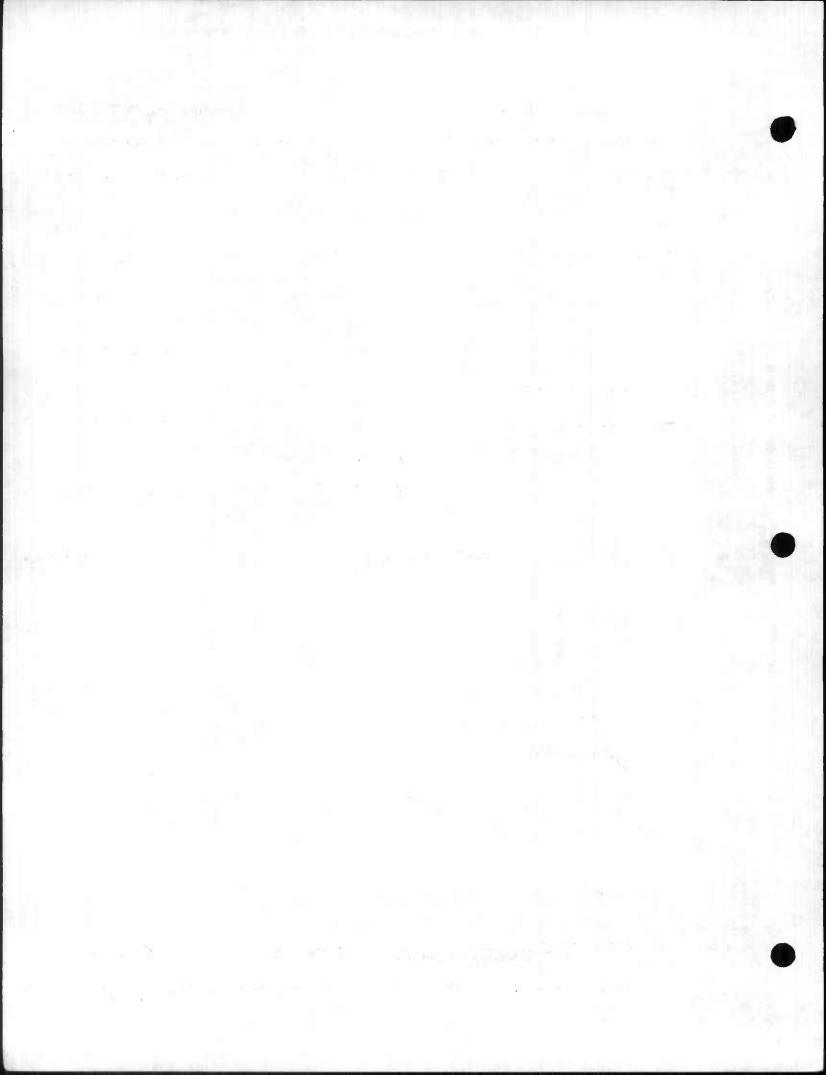
5 Pending

Investigetion

6 ☐ Could not be

18101 32. Ragistrar's Signature

Prince Philip Drive, Olmy MT 20832



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Joan Saunders Brindley December 18, 1999 8:27 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5932 Anniston Road Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Deys 1 M 2 N F 82 580-05-0352 Director October 10, 1917 **England** Usual Residence of Decedent 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Bethesda 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? Name 23s 5932 Anniston Road 20817 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. 11 Marital Status Black, White, etc. than "natural", or han the Medical Examiner 72 hours shar 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Tyes 2 No Specify Specify: White þ 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) 12 Amateur Marine Biologist Marine permit. Pages 1 and 2 should be filed.
Department of Health and Mental Hyg.
Important: If then 27 is mented other any Injury or other traumented other pages. 18. Mothar's Name (First, Middle, Maiden Sumama) 17. Father's Name (First, Middle, Last) 88 Robert Saunders Grace Wilkinson 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly G. Bandler/Daughter 5932 Anniston Road, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, cremetory or other place) Dec. 21 20s. Method of Disposition 20c. Location - City or Town. Stete 1 ☐ Burial 2 ACremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 4 Donation 5 DOther (Specify) 1999 Bethesda, Maryland 21. Signature of Funeral Service Ligary 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 Domen M00672 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Carcinoma of Breast with Metastasis disease or condition resulting in death) 3 Years Examine Due to (or as a consequence of): Examiner Old Cerebrovascular Accident 25 Years the deeth certificate be executed physician and the burief-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Hemiparesis (left) 25 Years Physician/Medical Due to (or as a consequence of) 8 strending p for use es PO 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. signed by it 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Š 24b. Were autopsy findings available prior to should bloom 24a. Was an autopsy performed? Completed completion of cause of death? page 2 s hee 1 Yes 2 No 1 Tyes 2 No certificate 8 25. Was case referred to medical 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 \$\times\$ Residence 6 Other (Specify) OL. 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of Certification: 28c. Injury at or Attending Patter death.

I Director: After d in by the funer 5 Pending investigation 1 X Natural 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

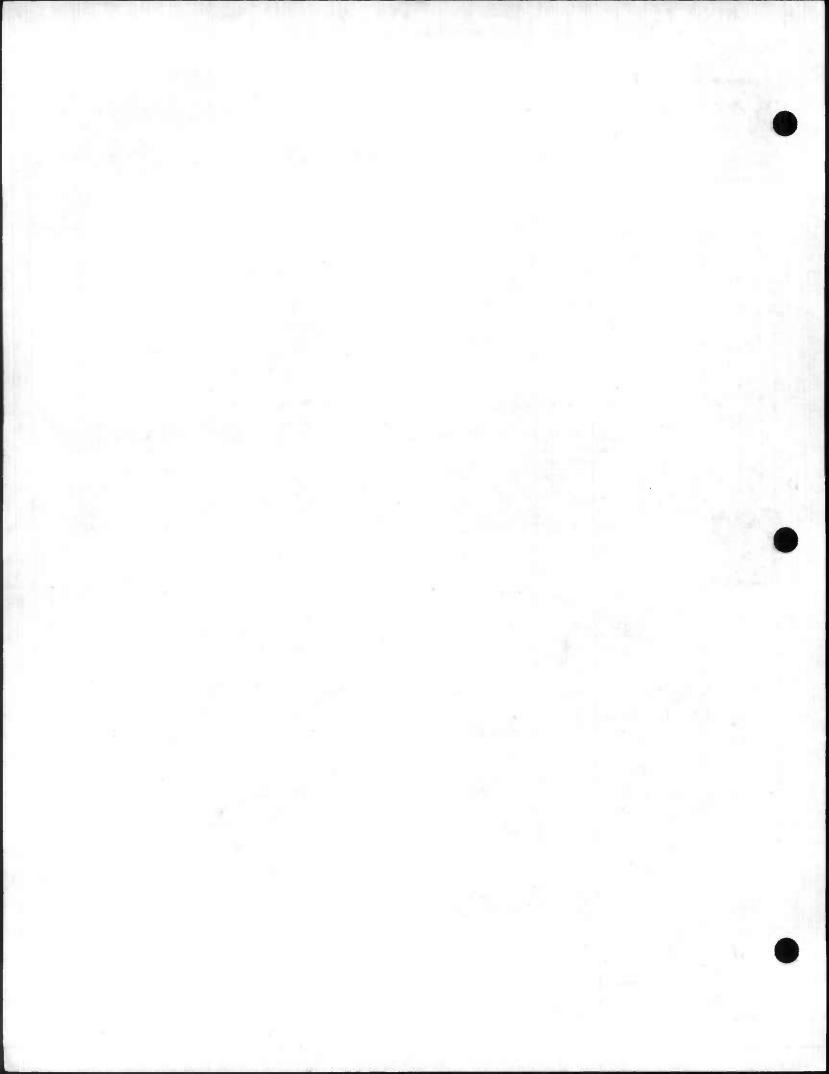
2 I Modest Examinat: On the basis of examination and/or investigation in my paidless, death edical 29a. Certifier On the basis of examination end/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie wire D20065 December 21, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eva M. Morell, M.D., 6000 Executive Blvd., #300, Rockville, Maryland 20852-3803 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature

DHMH 16 Rev 6/95

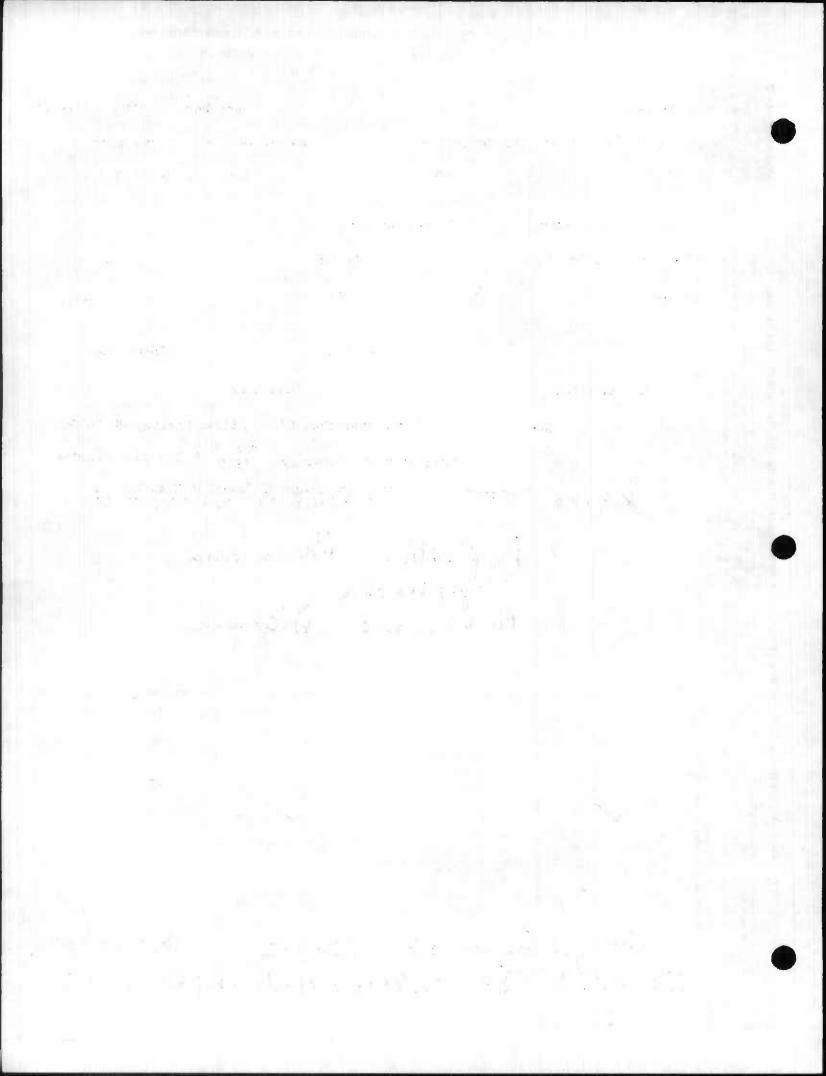
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Registrar

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	10e. Street and Nu	umber					10f. Zi	p Code			10g. Citizen of W	Vhat Countr	у?
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	/500		nt's Education	latad)		16a. Dece	dent's Usu	al Occupa	ation during most of work	ina	16b. Kind of Bu	siness/Indu	istry
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-		12					Sale	sman				rance	
	17. Father's Name	(First, Middle	, Last)						18. Mother's Name	e (First, Middle	, Maiden Sumam	10)	
	Louis	Brockm	an						Anna Le	vy			
1	19a. Informant's N	lame/Relation	ship (Type, Pnin	t)		19b. Maitir	ng Addres	s (Street	end Number or Run	al Route Numb	er, City or Town,	Stete, Zip (Code)
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	4 Donation			State	Sta	r of D	avid	Ceme		1999	Tamara	c, F1	orida
-	21. Signature	uneral Service	Licensee						ss of Facility		. 01 1		
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t	23a. Pert1. Enter	the disease, o	or complications	that caused	the death				ig, such as cardiac				Approximate Interval Between
rijelalismedical Evalime	Sequentially tist or if any, leading to licause. Enter Und Cause (Disease or that initiated event resulting in death)	lerlying r tnjury (ts	b	Parl	Uue to (or Due to (or	r as a consec r as a consec	quenca of)	_	Dice	are			
	Part II. Other signi	ificant conditi	d	g to death b	ut not resu	ulting In the u	nderlying	cause giv	ren In Part I.	23b. Did	tobacco use cor	ntributa to	the cause of death
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											an autopsy ormed?	com	re autopsy findings itable prior to apletion of cause eath?
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ŀ	25. Was case refe	rred to medica	al						26. Place of Deat	h (Check only	one)		
	examiner? 1 Yes 2 27. Manner of Dea 1 Natural 2 Accident	5 Pendi		1 ☐ tnpatie Date of Inju (Month, Da	ry	ER/Outpatier 28b. Time o Injury		28c. Injur Wor	4 Wursing Ho		idenca 6 □Oth how injury occurr)
	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could deter	mined 266.	Placa of Injuding, etc.		me, farm, str	reet, facto	ry, office		28f. Location (City or To	(Street end Numb wn, State)	er or Rural	Route Number,
	29a. Certifier (Check only one)		Examiner: On		examinat				ne, date and place, pinlon, death occur				
ı		d 4744 6 4747		4			29	c. Ltcens	e number		29d. Date signe	d (Month, D	Day, Year)
-	29b. Signatylu und	d tittle of cartific		- 4									
-	29b. Signaty June	guy	Cl Ceu	yter	sh	D	3)2	4942		DEC	17	1999



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 Amended Item 23a. Part I Per Phy., 12/22/99, Carroll County, wil Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Bates **Physician** William Clinton 10:10 Pm 12 /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER CARROLL 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4 / 19 / 1934 5. Sociel Security Number Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1⊠M 2□F 185-26-3759 65 PENNSYLVANIA Director Usual Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. Inside City Limits ahow na 23a or 28a-f show 1 ☐ Yes 2X No MD. CARROLL WESTMINSTER Director 10e Street and Number 10f Zip Code 10n. Citizen of What Country? 2470 SYKESVILLE RD. 21157 USA. Funeral 12. Wes Decedent Ever in U.S.
Armed Forces?

1 X Yes, 2 No KOREAN

If Yes, Give Yeer or Dates: CONFLICT

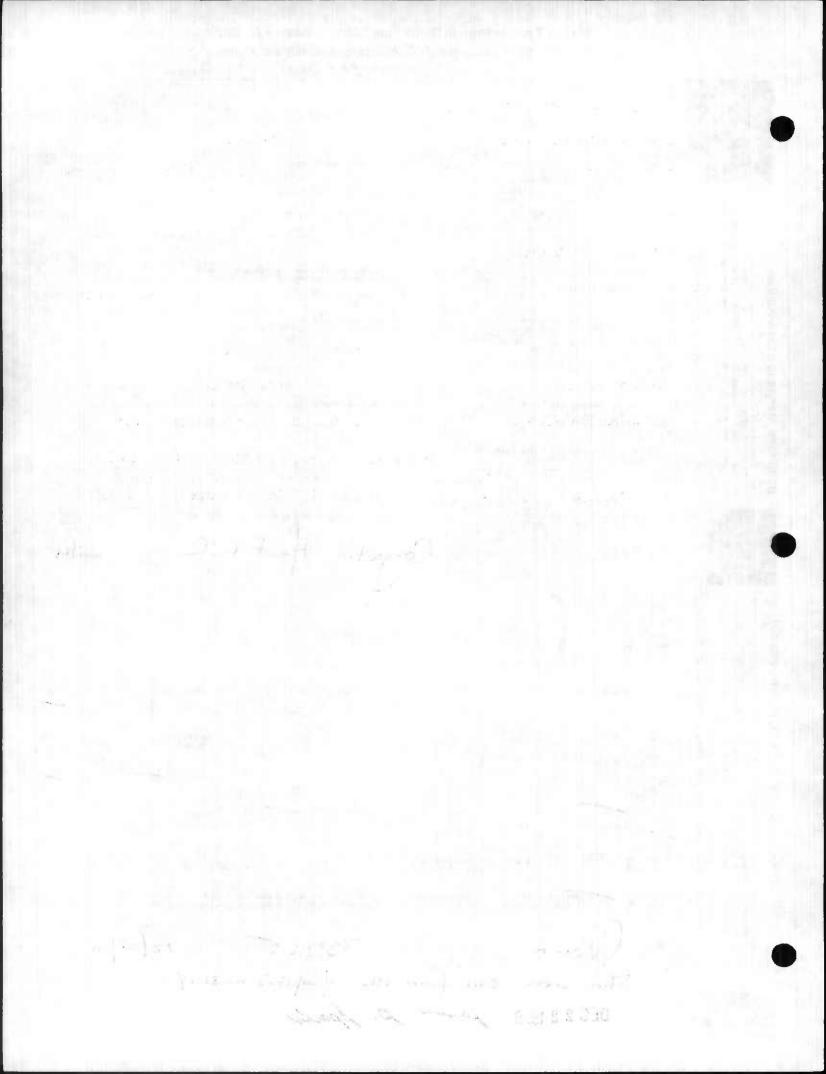
1 Yes 2 No Specify: Remen 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. filed within 72 hours after 1 ☐ Never Merried 21 Merried 21215-0020 ŏ Specify þ 3 Widowed 4 Divorced "natural". WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) EXPLOSIVE TECHNICIAN CONSTRUCTION .. Pages 1 and 2 should be filed witten of Health and Mental Hygien tant: If Nem 27 is marked other theirry or other traumatic event, the 12 Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be WILLIAM HENRY BATES SYLVIA DECKER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) DALE L. BATES -WIFE 2470 SYKESVILLE RD., WESTMINSTER, MD. 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 XBuriel 2 Cremetion 3 Removel from Stete Department of important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) 12/14/99 SMALLWOOD, MD. DEER PARK CEMETERY 21. Signeture of Fynerel Service Dicenses 22. Name and Address of Facility FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157 23a. Pert1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feiture. List only one cause on each line. **Physician** /Medical Immediate Cause (Finet 45 min disease or condition resulting in death) Examiner Examiner 2 WKS Multisystem 6 kgan The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): physician s the burial Box 68760. Bilateral Lung Infiltrates Physician/Medicai Due to (or es a consequence of): Myelodysplasia for use Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy 1 Yes 2 PNo 1 ☐ Yes 2 ☐ No. Division of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To this 28a. Date of tnjury (Month, Day Year) funeral 27. Manner of Deeth 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? After 1 Neturel 5 Pending 1 Tes 2 No 24 hours after death. 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifie (Check only one) within 2 \$ 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number 0 015552 Md. M.D. 2115 30. Name and eddress of person who completed cause of death (ttem 23a) (Type, Print) Heights Wastminster, md 224 Washington M.D 31. Dete fited (Month, Dey, Year) 32. Registrar's Signature State DEC 2 2 1999 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 99 4 747

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	1. Decedent's Neme (First, Middle, I	ast)						2. Dete of Deel		Yeer	3. Time of D	eath
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/Medical Examiner	4a Fecility Neme (If not institution, g				-	b. City, To	wn, or Lo	ocation of Deeth		y of Deeth	1	
	Long View Nursi	ng Home				Mano	chest	ter	C	arrol	11	
Funeral Director		-	(In yrs. lest birtho	Months	1 Year Deys	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day) Feb 8, 1	Year)	Cou	plece (Stete or i	Foreign
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permit. Pa Department: Important: any injury.	21. Signature of Funerat Service Lic	ansee MO	0723	22. Neme en 934				Eline Fu t, Hamps			1074	
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	30. Name and address of person wh	See all		01	4	aushit	Con	m2 2107	4			
CANA	31. Date filed (Month, Day, Year)		r's Signeture		1	1/2/			1			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Mary Lucille /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital
Social Security Number 6. Sex 7, Age (In yrs. las Clinton If Under 24 Hrs. Prince Georges If Under 1 Year Months Days 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Min. 10 M 20x Hours Director 219-16-0867 October 21,19 Maryland The Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Directo notifie Maryland Prince Georges Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? finer must be n 10609 North Keys RD U.S.A. 20613 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 72 hours after 1 ☐ Never Married 2 ☐ Married Pages 1 and 2 ahould be filed within 72 hours ath ment of Heath and Mental Hygeles in the list in the list in the list of the marked other than "natural", or I way or other traumatic event, the Medical Example usy or other traumatic event, the Medical Example 21215-0020 1 Yas 2 No Specify 3 ☐ Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Domestic altimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be Daniel Moore Lillian Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 10110 Queen Elizabeth Dr. Upper Marlboro Md 772 Richard Brooks- Son 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Department of important: If any injury or anse. 4 Donation 5 Other (Specify)

21. Signature of Juneral Service License St. Peters Cem Dec. 30,99 Waldorf MD 22. Nama and Addrass of Facility M00191 ADams Funeral Home P.A. Aguasco MD 20608 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner siclen end buriel-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) physicien the burie Box 68760, Physician/Medical Dua to (or as a consequence of): for use es Part il. Other significant conditions contributing to death but not resulting in the underlying causa given in Part i. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has funeral director, page 2 110/11 1 ☐ Yes 2 ☐ No 1 Yas Division of Vital or Attending Physician: 25. Was case refarred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 25 No Medical Certification: To 1 | Impatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attanding within 24 hours after death.
To the Funeral Director; Afte completely filled in by the fun 1 Yes 2 No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner as stated.

**Z | Medical Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar

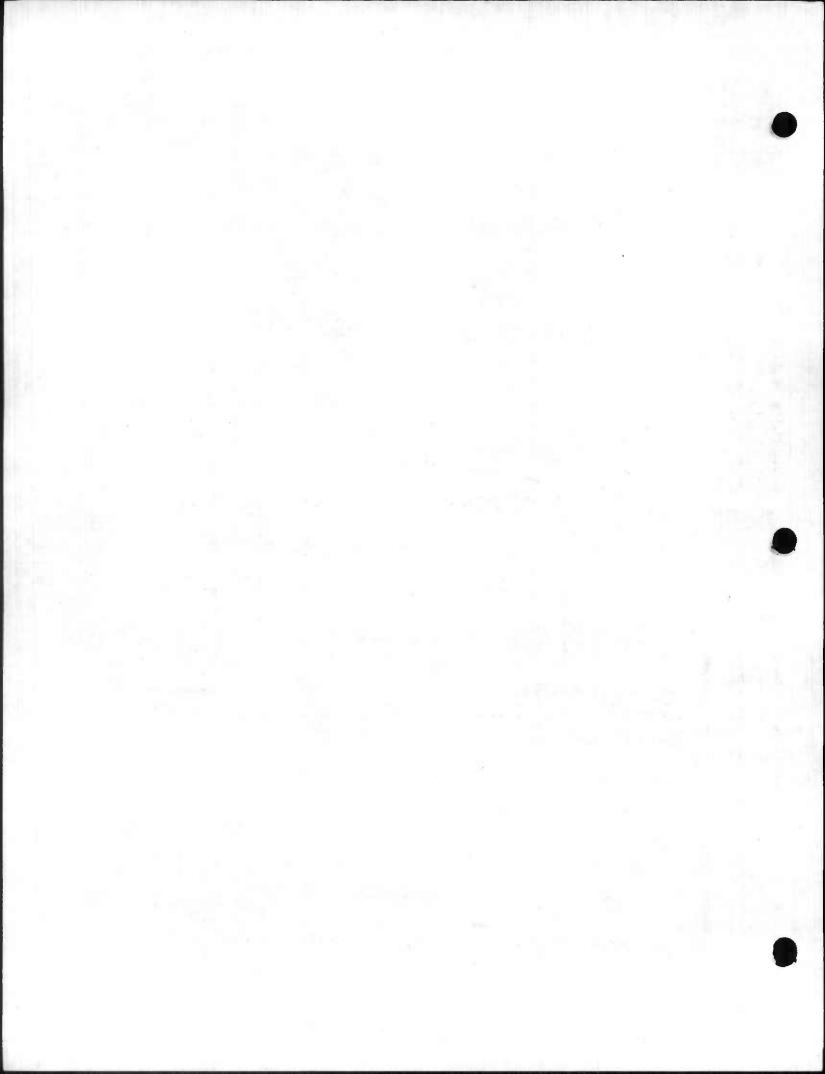
Rene Grace, MD

31. Data filed (Month, Pay, Year) DEC 28

Clinton, Maryland 20735

9131 Piscataway Road #260

32. Registrar's Signature



ian	1. Decedent's Name (First, Mid	dle, Last)		Ce	rtificate of	Dealli	2. Date of De			3. Time of Death
	Charles	Braden,	Jr.				Month Dec.	Day 18]	Year L999	10:30 AM
ical iner	4a Facility Name (If not institute Prince George			r		4b. City, Town, or Cheverly				
	5. Social Security Number 243 34 9872	6. Sex 1 M 2 F	7. Age (In yrs. 71	lest birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, De	th ly, Year)	9. Birthplac	ce (Stete or Foreig
	Usual Residence of Decedent	1111	1 /1				Nov. 2	0, 1928	Ten	nessee
	10a. State 10b. Coun	ty	10c. City	y, Town or Lo	ocation				10d	. fnside City Limit
	Maryland Princ	e George'	s La	nham						1□Yes 2□N
	10e. Street and Number 9418 Washingt	on Plud			10f. Zip Code	20706		10g. Citizen of V		
I	11. Marital Status		ecedent Ever in U,	6 12	Was Decedent of h		nacify Vac or No		e - American	
	1 Never Married 2 Ma 3 Widowed 4 Divorce	Armed 1 Yes	Forces?		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 No	Specify:	to Rican, etc.)	Blac Specify	k, White, etc	D.
ŀ	15. Decede	ent's Education	d)	16a. Dece	dent's Usual Occup	petion during most of wa	rkina	16b. Kind of Bu	siness/indu	stry
ŀ	Elementary/Secondary (0-12)		(1-4or 5+)		kind of work done DO NOT use retire	d)	· · · · · · · · · · · · · · · · · · ·	Manufa		ng Co.
-	17. Father's Name (First, Middle			Maci	inist	18 Mother's Na	me /First Middle	, Maiden Sumem		ng co.
	Charles Brade					Lena Fo		, Maiden Sumem	(0)	
	19a. Informant's Name/Relation	nshlo (Type, Print)		19b. Maili	ng Address (Street	end Number or R	ural Route Numb	er, City or Town,	Stete, Zip C	ode)
	Mernie E. Bra		Wife		Washing					
	20a. Method of Disposition		20b. P	Place of Dispo	osition (Neme of matory or other pla	Dec. 2	Pary 99	20c. Location -	City or Town	n, State
I	↑ Burial 2 Cremation 4 Donation 5 Other		m State _		coln Cem		,	Brentw	rood M	aryland
	21. Signature o Funeral Service	e Licansee	BAMANA	1	2. Name and Address ODETT E.					15
	immediate Cause (Final disease or condition resulting in death)		Due to (o)	LNSU (quence of):					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last	{	Due to (o	r as a consec	He Lu	ng				
	that initiated events	d	Due to (o	r as a consec	quenca of):	ven in Part I.	23b. Dfd	tobacco use con	ntribute to t	he cause of deat
	resulting in deeth) Last	d	Due to (o	r as a consec	quenca of):	ven in Part I.	1	tobacco use con √es 2□ No		he cause of deatl
	resulting in deeth) Last	d	Due to (o	r as a consec	quenca of):	ven in Part I.	10 24a. Was		3 Proba	
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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Lest) 2. Data of Daath December 19,1999 Sylvia A. Baden 2:33 A.M. 4a. Facility Nama (If not institution, give streat end number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery If Undar 1 Year If Under 24 Hrs. 8. Data of Birth
Months Deys Hours Min. NOVEMBET 5. Social Sacurity Number 9. Birthplace (Steta or Foreign County) Virginia 6. Sax 7. Aga (In yrs. last birthday) 1□ M 2XXF Months 82 Yrs. 577-32-1710 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 XX Maryland Prince Georges Upper Marlboro 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 14606 Willoughby Road 20772 U.S.A. Was Dacedant Ever in U,S. Armed Forcas? 14. Race - American Indien, Black, Whita, atc. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 □ Navar Married 2 □ Married 1 ☐ Yes 2 → No If Yas, Give X Yaar or Datas: Specify: white 1 ☐ Yas 2 ☐No Specify: Widowed 4 □ Divorced 15. Dacedant's Education (Spacify only highest grada complated) Decedant's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Elementery/Sacondery (0-12) College (1-4or 5+) Accountant Electricial Union 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maidan Surname) Jacob Blumberg Rose Bogosh 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Coda) Ann Marie Linkins/Daughter 14606 Willoughby Rd. Upper Marlboro, MD 20772 20e. Mathod of Disposition 20b. Placa of Disposition (Nama of cematary, cramatory or other place) Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery Dec. 23, 1999 Clinton, MD 22. Nama and Address of Facility Ft. Lincoln Funeral Home Signature of Funerel Sarvice Licent sa, or comblications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, Appro. List only one cause on each line. DISKAIK Immadiate Causa (Final CBSHRYCTIVE LUNG disaase or condition rasulting in deeth) Dua to (or es e consequança of Dua to (or as a consequence of): Dua to (or as a consequence of) 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 26. Plece of Deeth (Check only ona) Hospital: 1 Inpatient Othar: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 2 ER/Outpatient 3 DOA 28c. Injury et Work?

Physician /Medical Examiner

and

physician ar

signed l

peed page 2 certificate

Hospital or Attending Physician: 24 hours after death.
Funerel Director: After this certifica stelly filled in by the funeral director, g

24 hours a

To the Hosp within 24 hou To the Funer completely fil

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

Examiner

Physician/Medical

by

Be Completed

Certification: To

Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

ŏ items 23a

"naturel", or

traumatic event, the Madical Examiner

Director

Funeral

by

the Marylend

filed within 72 hours efter

In 1 and 2 should be filed within the Health and Mantal Hygiene. Item 27 is marked other than

8 Department of Important: If R any injury or o

Baltimore, Maryland 21215-0020

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Ceusa (Disease or Injury that initiated avants rasulting in daath) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

25. Wes cesa referred to medicel examinar? 1 Yes 2 No 27. Mannar of Deeth

5 Panding Invastigation

MI

address of person who completed cause of deeth (Item 23a) (Type, Print)

6 Could not ba datarmined

28a. Data of Injury (Month, Day Year)

28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

28b. Tima of

1 Yes 2 No

28d. Dascribe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifier

1 Neturel

2 Accidant

3 Suicida

4 - Homicide

1 Cartifying Physician: To the best of my knowladga, daath occurred at the tima, data and place, and dua to tha causa(s) and manner as steted. 22 Medical Examinar: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred et the time, data and place, and due to the cause(s) end mannar stated.

29b. Signatura and title of certifian

31. Data filed (Month, Day, Year)

1602B1

DEC 2 3 1999

29d. Date signed (Month, Dey, Yaer)

State Registrar

BELIRET ROAD, 6525 6/ max 32. Ragistrar's Signetura

DHMH 16 Ray 6/95

State of Maryland / Department of Health and Mental Hygiene O

Amend#'s 25.27.& 28a.thru 28f.PGC ME 12-23-99 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day **Physician** December 9, 1999
cation of Death 4c. County of Death 11:05am James Ernest Blue, Jr. /Medical 4a Facility Neme (If not Institution, give street end number) 4h. City. Town, or Location of Death Examiner Prince George's Hospital Prince George's Cheverly If Under 1 Year If Under 24 Hrs. 8. Dete of Birth
Hours Min. (Month, Dev. Year) Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) 6. Sex **Funeral** 10℃ M 2□ F Months Days Yrs. Director 578-88-8626 31 October 4,1968 Washington, D.C Usual Residence of Decedent the Marylend 10c. City, Town or Location 10a Stete 10h Counts 10d. Inside City Limits ahow "natural", or items 23s or 28s-f show Washington, D.C. 1√2 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 1203 Floral St. N.W. 20012 United States death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indien, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours sfter 12 Never Married 2 Married Specify: Black 1 ☐ Yes 2 ☒ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced nd 2 should be filed within 72 hou lith and Mental Hyglena. 27 Is merked other than "natural r traumatic event, the Medical E. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) Private Cable Technician permit, Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other
any Injury or other traumatic event,
pages. 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be James Ernest Blue, Sr. Rosalee Huff 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Reletionship (Type, Print) 20012 1203 Floral St. N.W. Washington, D.C. Rosalee Blue /Mother 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) Date 20c Location - City or Town, State t ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 12/14/99 Silver Spring, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentee 22. Name and Address of Facility
Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestv 20747 5538 Marlboro Pike/Forestville, Md. 23a. Pert1. Enter the disease or complications that a used the shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner that the death certificate be asscuted physician and s the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest O. Box 68760, Physician/Medical for use es With Did tobacco use contribute to the cause of death? signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying caus 1□Yes 2□No 3 Probably 4 Rinknown by The law requires 24b. Were autopsy findings available prior to been si 24a. Was an autopsy Completed completion of cause of death? cartificata hes t 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: TX Yes t ☐ inpatient Certification: To R/Outpatient 3 DOA Sir! After thi funaral 28d. Describe how injury occurred VS 28b. Time of 28c. Injury et Work? 27. Manner of Death 28e. Dete of Injury (Month, Dev Year) 5 Pending death. 11-05-99 0300AM 1 Yes a No 2 Accident investigation FIXED GESTECT COLLISION after death Director: A 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 5. DAKOTA & RIGGS RO hin 24 hours aft the Funeral DI npletaly filled in STREET Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es steted.

Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and manner stated. Medical 29a, Certifier To the I within 2 To the I complet 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of contifier 29c. License number cember 11, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 Hospital Dr. Cheverly, Md. 20785 Meera Kanhouwa, M.D. 31. Date filed (Month, Day, Year)
DEC 2 3 1999 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95

5.

THE DECK MARKETERS.

Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev Year DECEMBER 13 199 eation of Deeth 4c. County of Deeth **Physician** Annie Breece /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner CLINTON PHNCE 8301 DANGERFIELD PLACE If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex Months Deys Hours Min 1□M 2√2 F Yrs. 152-12-3952 91 11/24/08 N.J. Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ¥PYes 2□No Director Clinton MD P.G. 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8301 Dangerfield Pl. 20735 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Meritel Status Bleck, White, etc. 1 □ Never Merried 2 □ Married 1 Yes 2 No Specify: Specify: Black by 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Coilege (1-4or 5+) Elementery/Secondary (0-12) Factory Worker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Tran Sawyer 2 Addline Johnson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Johnson/great neice 8301 Dangerfield Pl.Clinton, MD. 20735 20b. Pleca of Disposition (Name of cemetery, crematory or other place) Date 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriei 2 ☑ Cremetion 3 ☐ Removel from Stete Chesapeake Crematory12/18/99 Beltsville, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Hodges and Edwards 21. Signature of Funeral Service License 3910 Silver Hill RD.Suitland, MD.20746 award 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death Immediate Cause (Final . ARTER-OSCUEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in deeth) Due to (or es e consequenca of): Examine Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yee 2 No by 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy Completed performed' 1 ☐ Yes 2 No 1 □ Yes 2 □ No 25. Wes case referred to medical exeminer? Be 28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending Naturel 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29e. Certifier (Check only one) Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end manner es steted. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner-stated. edical

requires that the death certificate be axec Division of Vital Records, P.O. Box 68760, or Attending Physician: Hospital

Funeral

Director

with the Maryland

Pages 1 and 2 should be filed within 72 hours after deeth with the Maryian nant of Haalth and Mental Hygiena.

net: If tem 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Macacal Examiner must be notified at

permit. Page Department of Important: If any Injury or

Physician /Medical

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Baltimore,

State JAN Registrar

29b. Signatura

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MO 32. Registrer's Signature

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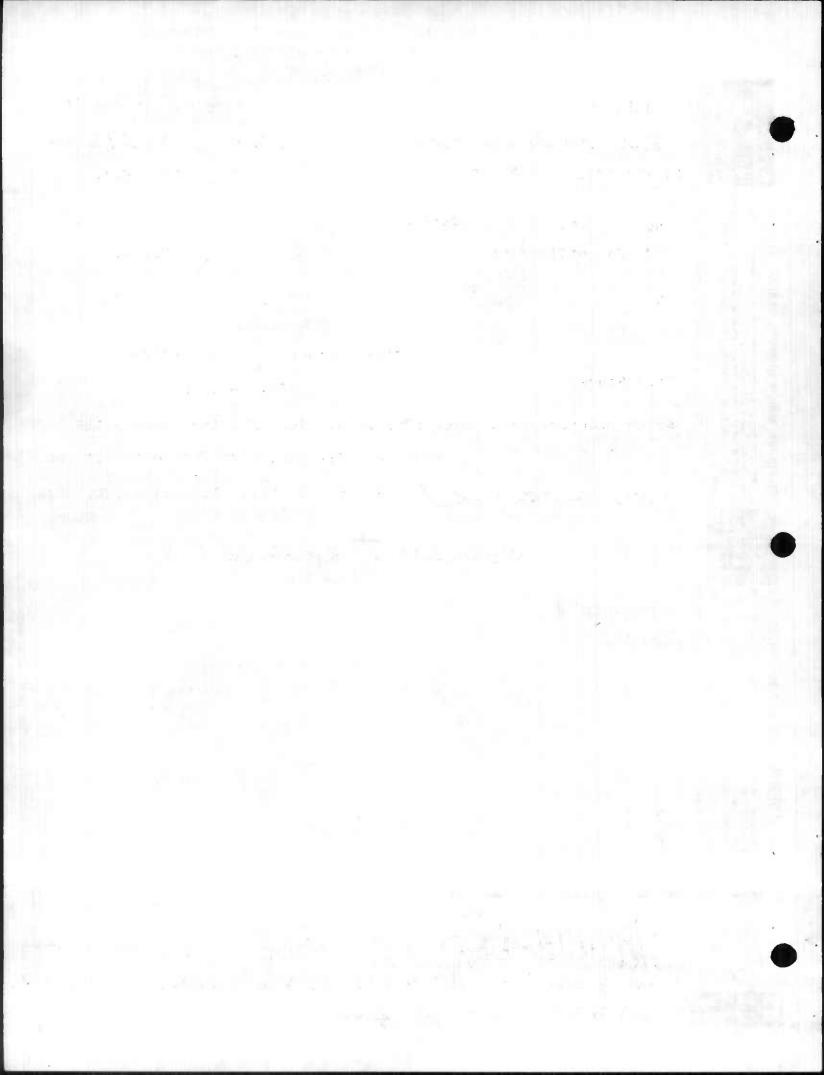
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29d. Date signed (Month, Day, Year)

CHEVERLY MARYLAND 20785

DECEMBER 13, 1799

QHMH 16 Ray 6/95



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About of A	_					artment of I rtificate of			Reg. No.	*7	1700
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Examin	er	4a. Fecility Name (If not Institution NATIONAL]	on, give street end nu LUTHERAN	mber) HOME			4b. City, Town, ROCKVI	or Location of Dea		of Death	RY
Funeral Director		5. Social Security Number 578-10-3080	6. Sex 1 ☐ M 2 【X F	7. Age (In yrs. le	st birthday) Yrs.	if Under 1 Year Months Days		lin. (Month, D	rth ay, <i>Year)</i> 29,1912	9. Birthpi Count WAS	ece (State or Forei
28a-f show	tor	Usual Residence of Decedent 10a. State 10b. Count MD • MOI	Y NTGOMERY	10c. City,	Town or Lo	cation CKVILLE		-11		10	Od. Inside City Lim
23s or 28s	al Director	10e. Street and Number 9701 – VE	IRS DRIV	E		10f. Zip Code	20850		10g. Citizen of US		try?
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27 is m		19a. Informant's Name/Relation	ship (Type, Print) HARD-EXE	CUTOR	19b. Mallin 970	g Address <i>(Street</i> 1 – VEIR	end Number of	Rural Route Numb	Der, City or Town	Stete, Zio	850
6 = 0		20a. Method of Disposition **Disposition 2 Cremation 4 Donation 5 Other (3)		State 20b. Pla	ce of Disponetery, crem	sition (Neme of netory or other ple COLN CE	METERY	Dete 7-12/21	20c. Location BRENTW		
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g physicia as the bur	8	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Ot c. Hy	vial	as a consequence of the conseque	Shvi uence of):	T Ra	ilure		4	Months Smonth Lears
ache	Physician/M	Part II. Other significant conditi	ons contributing to de	eath but not regult	ing in the ur	dedying cause give	ren in Part I.		tobacco use co	ntribute to	the cause of dea
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Is certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2□ El	R/Outpatien!	3□ DOA Oth	or /	Death (Check only		or /Sopoih	1
E =		27. Manner of Death 1 ☑ Natural 5 ☐ Pendii 2 ☐ Accident Invest	28a. Date (Monti igetion		8b. Time of Injury	28c. Injui Woo			how Injury occur		,
500	Certification:	3 Suicide 6 Could 4 Homicide determ	nined 289. Place	of Injury - At hom ng, etc. (Specify)	e, farm, stre	et, factory, office			Street and Numb wn, Stete)	oer or Rurai	Route Number,
within 24 hours after To the Funeral Dir completaly filled in	edical	29a. Certifier 1 Certifyli (Check only one) 2 Medical	ng Physician: To the Examiner: On the be and man	best of my knowle asis of examination ner stated.	edge, death n and/or inv	occurred at the tir estigation, in my o	ne, dete and pla pinion, death o	ica, and due to the ccurred at tha time,	date and placa,	anner as sta and dua to	ited. the cause(s)
Toth	2	29b. Signature and title of certifie	ew. Kee	rosh v	2	29c. Licens 2	e number . 1726		29d. Date signe	d (Month, E	Pay, Year) 1990
2		30. Name and address of person DR • CHARLES					R., RO	CKVILLE	,MD.		

April 6. march 388 6 5 3 30

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER 18,1999 MILDRED W. 1:20am BANKS /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner OLNEY MONTGOMERY MONTGOMERY GENERAL HOSPITAL If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** 1 M 2 D F Months Days Hours 92 Yrs. MARCH 17,1907 WASHINGTON DC Director 577-14-1164 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10b County the Maryl 1X Yes 2 □ No MD MONTGOMERY SILVER SPRING Directo 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? mant be n 14217 RIPPLING BROOK DR. 20906 UNITED STATES 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 yemii. Pages 1 and 2 should be liked within 72 hours all 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa ratired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OFFICE WORKER GOVT 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H ann: if Item 27 is marked oth lury or other traumatic even Be ROBERT WASHINGTON MILDRED KEMPER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DELORES LARREQUI / DAUGHTER 14217 RIPPLING BROOK DR. SILVER SPRING 20906 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Department or important: If any injury or once. CHESAPEAKE CREMATORY 12-20-99 BELTSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
POPE FUNERAL HOMES paral Service Licenses 11315 LOCKWOOD DRIVE SILVER SPRING, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death Physician /Medical Immediata Cause (Final disease or condition resulting in death) Examiner Examiner physicien and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): requires that the death certificate be exec Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequenca of) 98 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 | Yes 2 | No þ 24b. Wera autopsy findings available prior to Completed 24a. Was an autopsy performed? Dementa completion of cause of death? certificate has b lirector, page 2 s 1 ☐ Yes 2 No or Attending Physician: 25. Was casa rafarrad to medical examiner? 28. Placa of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Nopatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) funerel 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending 1 ☐ Yas 2 ☐ No investigation 24 hours after deel Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Hospital Certifying Physician: To the best of my knowledga, death occurred at the tima, date and placa, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier within 24 hot To the Fune completely fi edical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier December 18, 1999 038262 6 30. Neme and address of person who complated cause of daath (Itam 23a) (Type, Print) BUD Sule 340 Rockville MD 20850

Registrar

Dr Menchivalta 31. Date filed (Month, Day, Yaar)

32. Registrar's Signatura

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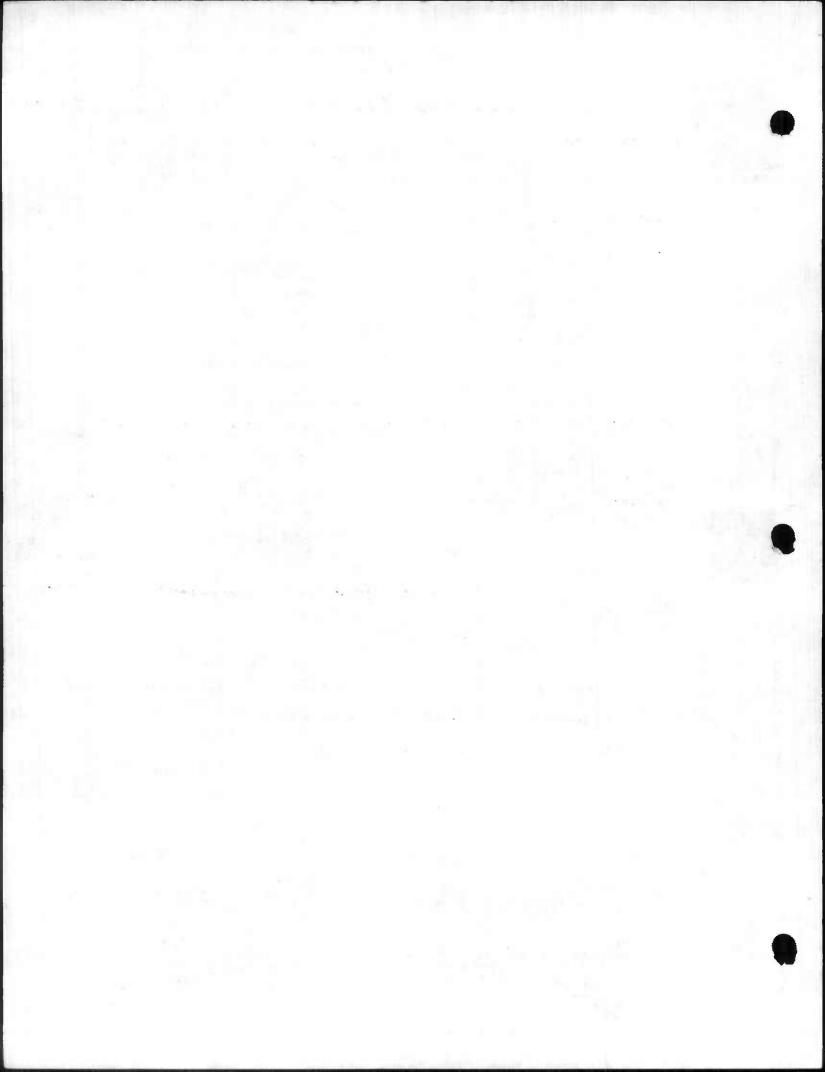
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** 4:23 AM CAbeZON FRANCISTO CASTILLO 20 1499 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** | Silver Spring | ff Under 1 Year | ff Under 24 Hrs. | 8. Data | Months | Days | Hours | Min. | (Mon Holy Cross Hospital Montgomery 6. Sex 1 M 2 F 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months Yrs. 73 Director 578-76-5081 Oct 26, 1926 Spain Usual Rasidance of Decedant death with the Maryland 10b. County 10c. City, Town or Location 10d. fnside City Limits ahow r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yas 2 No Directo Maryland Montgomery Kensington 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2601 Calgary Avenue 20895 Funeral USA 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ဩ No If Yas, Giva Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status filed within 72 hours after 1 Nevar Married 2 Married 21215-0020 1 Yas 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) 5+ Artist Painter ん Baltimore, Maryland permit. Peges 1 and 2 should be filed Department of Health and Mentel Hyg Important: If Item 27 le marked other any Injury or other treumatic event, 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Antonio Castillo Laura Cabezon 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Angela Castillo / Wife 2601 Calgary Avenue, Kensington, MD 20895 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Metropolitan Crematory 12/21/99 Alexandria, VA 21. Signatura of Sunaral Sarvice Licensaa 22. Nama and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Entar tha diseasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on you cause on each line. Approximate fntarval Between Onset and Death Physician /Medical Immediata Causa (Final Stroke disaasa or condition rasulting in daath) Examiner Dua to (or as a consequence of): Glean comenf sician and burial-transit or Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Box 68760. Physician/Medical the Dua to (or as a consequence of): P.O. been signed by the a should be detached to Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Tribillation (choice) Records, by 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? ypertoneed. Hyper choleston Comic 1 ☐ Yes 2 ☐ No 1 Yas 2 PNo certificate Division of Vital 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) 1 Yas 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending Invastigation 24 hours after deeth.

Funerel Director: Af 1 | Yes 2 | No 2 Accident 6 Could not be within 24 hours after der To the Funeral Director completely filled in by the 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) \$ 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 2 008188 12-20-1499 15 40 Bracia 6 30. Nama and addrass of person who comptated causa of daath (Item 23a) (Type, Print) 717 PERSHING DRIVE MO GRAZIAN; HU60 MD G SPRING. 32. Registrar's Signatura 31. Data filed (Month, Day, Year) State **DEC 21** Registrar

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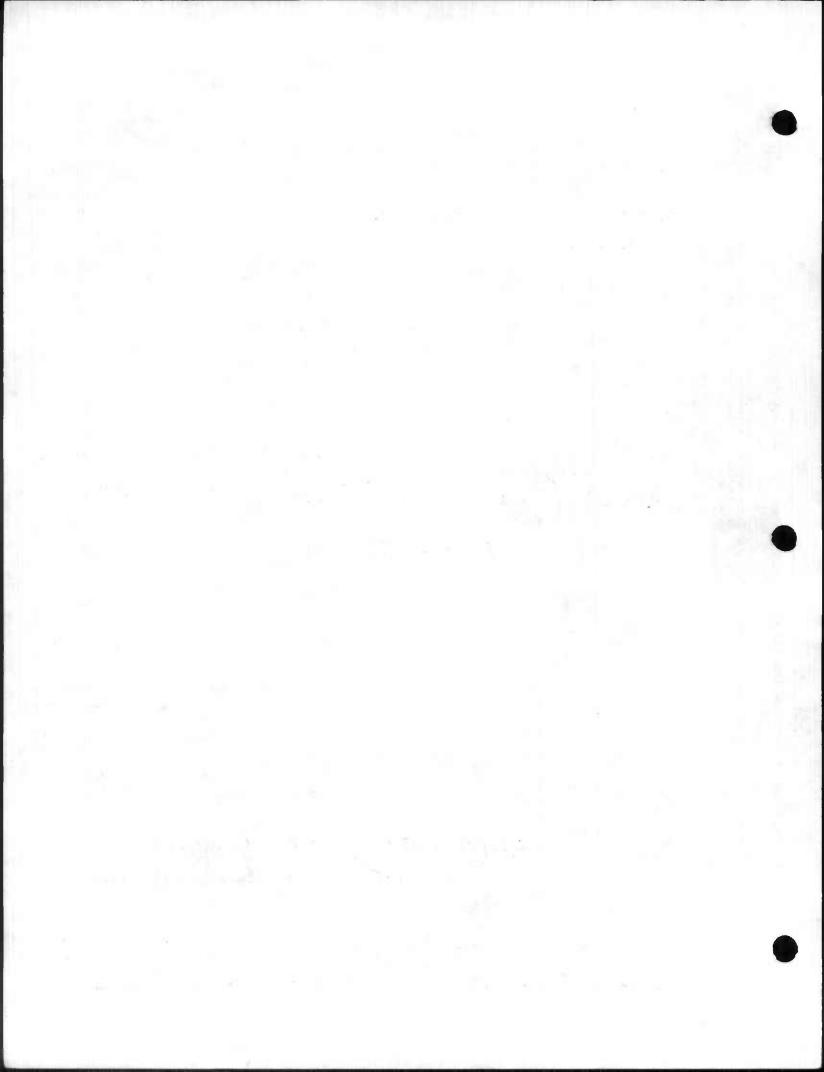


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	Funeral	5. Social Security Num			7. Age (In yrs. la	st birthday)	If Under 1		If Under	24 Hrs. Min.	8. Date of Bir		-	place (State or Foreign	
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Registrar

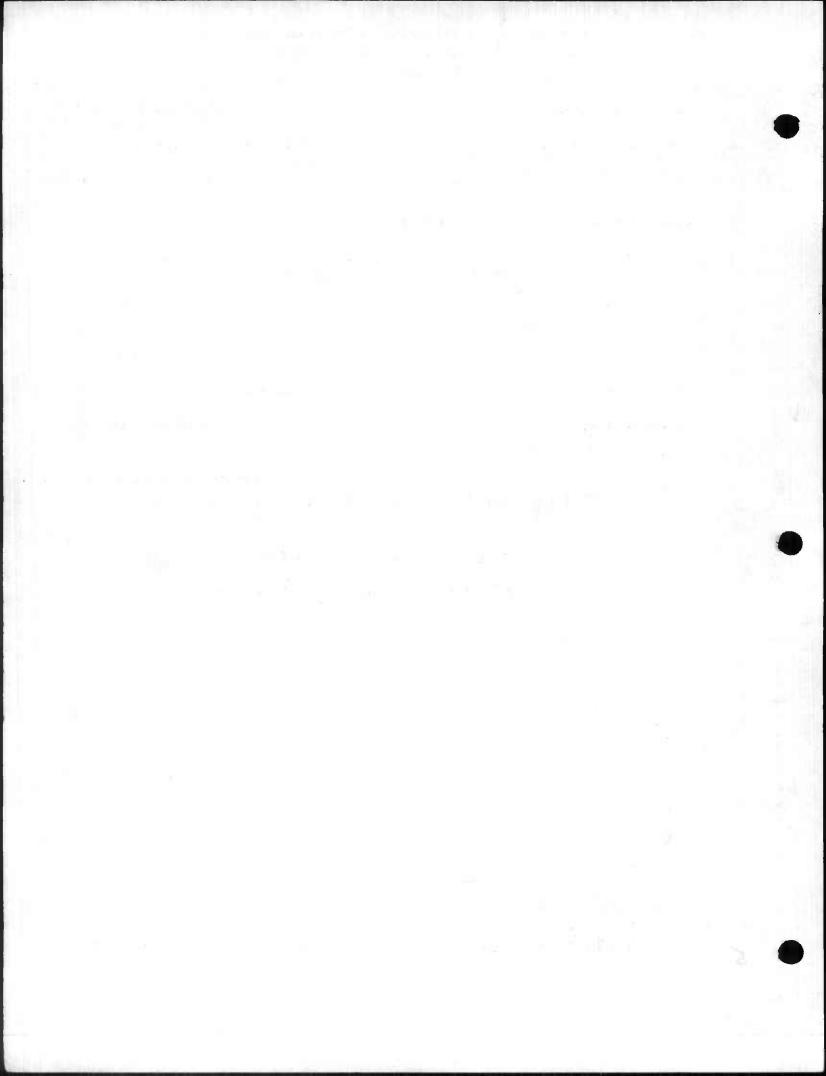
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Baltimore, Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours afte Depertment of Health and Mental Hygiena.
	Phy: /Mc Exa
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attanding Physicien: The law requires thet the death certificete be axecuted within 24 hours after death.

CHARLEY, ORVILLE

					Cer	tificate	of	Death			Reg. No.		7176	, ,		
L.E.,	30	1. Decedent's Name (First, Middla, L	.ast)							2. Date of D	eath		3. Time of	Death		
Physici:		Orville L. Charl	_ey							DECEMI	BER 17.	Year 1999	8:28 P	.м.		
/Medic Examin		4e. Fecliity Name (If not institution, g						4b. City, To	own, or L	ocation of Dea		ity of Death				
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Funeral			Sex 7. Age ((In yrs. last b	birthday)	If Under 1		if Under	24 Hrs.	8. Date of B	irth		place (Stata or	r Foreign		
Director		533-20-8244 Usual Residence of Decedent	XXM 2□F	71	Yrs.	Months	Days	Hours	Min.		(Month, Day, Year) Jun. 21, 1928 Washington					
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or 28	Director	10e. Street and Number				10f. Zip (ode				10g. Citizen o	f What Cou	ntry?			
23a	le le	16500 NE 182nd Av	re.			9860)6				United	State	S			
er w	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?		13. W	Vas Decede	int of H	lispenic Or	igin? (Sp	ecify Yes or N Rican, etc.)		ace - Ameri lack, White,				
Department of Haalth and Mental hygiena. Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Ft	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorcad		9/46	+	☐ Yes 2		Specify:		Thousand Story	Spec	.14	hite			
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Hygi ther ant, t		17. Father's Name (First, Middla, Las	st)	11	Luck	DITAE	: L	18. Moths	ar's Name	e (First, Middle	a, Maidan Suma		LUII			
ed o	o Be	Ray Charley	,						≥1 W:		.,	/				
mark math	To	19a. Informant's Name/Relationship	(Typa Print)	10	9h Mailin	n Address	Street				ber, City or Tow	r State 71	n Code)			
Ith ar		David Charley -S									ardtown					
Haa	11	20a. Mathod of Disposition		20b. Place	of Dispos	ition (Name	of			Date	20c. Location					
ment of lant: If I		1 ☑ Burial 2 ☐ Cremetion 3 4 ☐ Donation 5 ☐ Other (Space			Ever orial	greer Gard	lens	s Ceme	eter		Var		er, WA			
npor ny in		21. Signature of Funeral Service Lice	energy (20	22.	Name end	Addre	ss of Facili	ty Met	tropoli	tan Fun	eral	Servic	e, In		
0 5 5 0	, e , e , o	Strum 21	1 Iroddel	20	5.5	517 Vi	ne	Stree	et, A	Alexand	lria, VA	2231	.0			
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the	e death. Do	o not ente	r the mode	of dyir	ng, such es	cardiac	or respiratory	arrast,		Approximate Interval Baty) veen		
nysician			, one dade on dade mo.										Onset end D			
Medical		Immediata Cause (Final diseese or condition	HVA	1100	6.11	7.	15	ADE	Tina							
aminer		resulting in death)	e. / 1/02	ue to (or as a	a consequ	uence of):	1	TICC	170							
**	Examiner		e. Myod	DUA	0.7	ART	-12	1/)),	ACA		1				
rans	am	Sequantially list conditions,	Di.	e to (or as	a cansequ	ienca of):		1		136						
ian a		if any, leading to immediate causa. Entar Underlying Cause (Disaase or Injury										i				
hysic the b	llca	that initiated events														
ging p	Medical		l d									1				
e ettending physician and d for use es the bunal-transit	lcian	Pert II. Other significant conditions	contributing to death but u	not resulting	in the un	deduing car	ico div	en in Part I		23h Did	I tobacco uae c	ontribute t	to the course o	f dooth?		
d by the	Physic			not rooditing	111 (110 011	donying out	ado gir	on and and	•		Yes 2 No		le.	Jnknown		
be d	by															
s been signed by the	Completed										s an autopsy ormed?	av	Vere eutopsy file vellable prior to ompletion of cat death?			
page 2	E									4	Yes 20 No		□ Yes 22X	Ma		
certificate rector, pa	C	25. Was case referred to madical						an Dise					1195 2/21	do.		
irect	0	examiner? 1 1 Ves 2 □ No	Hospital:	0 C FD/0		Mood	Oth	er _		h (Check only						
To the Funeral Director: After this certific completely filled in by the funeral director.	-	27. Manper of Death	1 ☐ Inpatient 28a. Date of Injury		. Time of						how injury occi		(V)			
Afte	to	1 Natural 5 ☐ Pending	(Month, Day Y	'ear)	Injury	м	c. Injur Wor	k? Yes 2□		-	-					
ctor: y tha	fica	3 ☐ Suicide 6 ☐ Could not	be One Blace of Injury	- At home	farm. stre					28f. Location	(Street and Nun	nber or Rur	a <i>l R</i> outa Numi	ber.		
Dir.	Certification:	4 ☐ Homicida	building, atc. ((Spacify)	iaini, stro	ot, rabiory,	011100				wn, Stata)	1001 01 1101	ar riouta i varri	,		
fillec		29a. Cartifier 1☐ Certifying P	hysician: To the best of n	ny knowlado	ne death	occurred at	the tin	ne date an	d nlana	and due to the	cause(s) and n	nannar ae i	stated			
- Fur letely	edical		miner: On the basis of ex and manner stated	camination a	and/or Inva	astigation, l	n my o	pinion, dea	th occurr	ed at the time	, data and place	, and due t	o the causa(s)			
omb	Me	29b. Signature and title of certified				29c.	Licens	e number		- T	29d. Date sign	ed (Month,	Day, Year)			
		/ Ms	no Stann	\		λ	14:	285			12-	18-9	19			
5		30 Name and address of passer ::	v jor v'il) th //tom 00:	\ (T			-03					1	-		
		30. Name and addrass of person who					11 <i>†</i>	Rd T	eone	rdtown	MD 20	650				
Cto	10	William D. Boyd, 31. Data filad (Morith, Day, Year)	32. Degistrar's		TILL	LUUKO	uL	nu, I	reolis	TTGLOWII	, FID 20	0.70				
Stat Registra	-	DEC 23 19	399 Sener		9.	Spa	Ks									



									- H				
I. Decedent's Nam		ast)				Date of Dee Month	Dey	Year	3. Time of D				
CHU-MU C									ECEMBE			8:30 A	
a Facility Name (If not institution, g	ive street end n	um <i>ber)</i>			4	Ib. City, For	wn, or Location	on of Deeth	4c. Count	y of Deeth		
. Sociel Security N	lumber 6.		7. Age (In yr	s. last birthdey)				24 Hrs. 8.1	Dete of Birth	Year)	9. Birthp	lace (Stete or I	
		1 X X 2 U F		71 Yrs.		/-		DI	EC. 18	1927	TAIW	AN	
	10b. County		10c. (City, Town or Lo	ocation						1	0d. Inside City	
												1 ☐ Yes 2	
		RY	ROC	CKVILLE									
De. Street and Nu	mber				10f. Zip C	ode							
5 VANDER	BILT COU	RT			2085	0						,	
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1 Never Merr	ied XX Merried	1 Tes	20XNo					, rueno mos	11, 010./			elC.	
3 Widowed	4 Divorced	Yeer or	live Detes:		1 Yes Z	X No	Specify:			Speci	Specify:		
	15. Decedent's	Education		16a. Dece	dent's Usuet (Decupa	ation			16b. Kind of Business/Industry			
	cify only highest g	rade completed		(Give	kind of work	done o	during most	of working					
	ondery (0-12)	College	(1-4or 5+)					TRONT		(DI OV)	ED.		
	(First Middle Are	41		IMPO	RT/EXP	JKI							
/. Fathers Neme	(I-IISI, MIGGIO, LAS	it)					18. Mothe	rs Name (Fil	'SI, Middle, i	Maiden Sumei	me)		
CHAO CHEN							CHOUT	I LI					
19a. tnforment's N	eme/Retetionship	(Type, Print)		19b. Maiti	ng Address (S	Street a	and Numbe	or or Rural Ro	ute Numbe	r, City or Town	, State, Zip	Code)	
ENHUNG C	HEN (SON	()	25 VANDERBIL					ROCKV	MARYL	AND 2	0850		
			Piece of Dispo	sition (Neme	of		. D	ate					
XX Burial 2	Cremetion 3		Stete	cemetery, cre	matory or other	er plac	:0)	DEC	.19,				
AM Burial 2 Cremetion 3 Libemovetfrom Stele											VILLE, MARYLAND		
disease or condition	(Final on	a. METAS							.1			2½ YEAR	
											i		
		b. ANOREXIA								i	1 MONTH		
Sequentially tist co	nditions,		Due to						1				
ause. Enter Unde	erlying												
het initieted events	Lest	c Due to (or as a consequenca of):									1		
		d											
Part It. Other aignit	licant conditions	contributing to	death but not re	sulting In the u	nderfylng cau	se give	en in Pert I.		23b. Did to	obacco uae co	ontributa te	the cause of	
								200	1 🗆 Y	aa 2KMo	3 □ Pro	bably 4 🗆 Ur	
									24a. Was e	en eutopsy	24b. W	ere autopsy fin	
									perfor	med?	00	ailable prior to mpletion of cau	
											of	death?	
									1□Y	es XX No	1[∃Yes 2□N	
5. Was case refer	red to medical						28. Place	of Deeth (C	neck only or	ne)			
	No	Hospital:	Inpatient 2	☐ ER/Outpatier	nt 3 DOA	Othe	er: 4 Nu	rsing Home	XIX Resid	enca 8 □Ot	her (Specil	(v)	
1 Yes 20			of tnjury	28b. Time o		tnjun	y at	28d.	Describe h	ow Injury occu	rred	,	
				tnjury									
1 ☐ Yes 2☐ 7. Menner of Deat 1☐ Netural	h 5 Pending	(Mo	nth, Day Year)	,,	M	1111	Yes 21 I	No !					
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1 ☐ Yes 2€ 7. Menner of Deat 1 ☐ Netural 2 ☐ Accident	h 5 Pending Investigeti	on 28e. Plea		home, farm, str			Yes 2Ur		Location (S City or Tow	treet end Num n, State)	ber or Rure	I Route Numbe	
1 ☐ Yes ②☐ 7. Menner of Deat 1 ☐ Netural 2 ☐ Accident 3 ☐ Suicide	5 Pending Investigeti 6 Could not determine	(Moo	a of tnjury - At ding, etc. (Spec	home, farm, sto	reet, factory, o	office		281.	City or Tow	n, State)			
1 ☐ Yes ②☐ 7. Menner of Deat 1 ☐ Netural 2 ☐ Accident 3 ☐ Suicide	h 5 Pending Investigeti 6 Could not	28e. Plec build	ea of tnjury - At ding, etc. (Spec	home, farm, str	reet, factory, o	office	ne, date end	28f.	City or Tow	n, State) ause(s) and m	anner as s	teted.	
	la Facility Name (25 VANDE 5. Social Security N 259-87-0 Jauat Residence of 10e. State MARYLAND 10e. Street and Nu 25 VANDER 11. Merital Status 1 Never Merr 3 Widowed (Special Security N 17. Father's Name CHAO CHEN 19a. Informent's N VENHUNG CO 20e. Method of Dis XM Burial 2 4 Donetion 21. Signature Facility Security Sec	La Facility Name (If not institution, g. 25 VANDERBILT CO. 5. Social Security Number 6. 259-87-0507 Jauat Residence of Decedent 10b. County 10c. State 10b. County 10c. State 10b. County 10c. Street and Number 10c. Street 10c. S	La Facility Name (If not institution, give street end in 25 VANDERBILT COURT 6. Sex 259-87-0507 Description of Decedent 10e. Stete 10b. County 10e. Stete 10b. County 10e. Street and Number 12. Wes Decedent 10e. Street and Number 12. Wes Decedent 12. Wes Decedent 13 Widowed 14 Divorced 14 Wes Of 15. Decedent's Education (Specilly only highest grade completed 17. Father's Neme (First, Middle, Last) 17. Father's Neme (First, Middle, Last) 18. Informent's Neme/Reletionship (Type, Print) 19. Informediate Causa (Final disease or condition resulting in deeth) 19. ANORE 19. AN	La Facility Name (If not institution, give street end number)	A Facility Name (If not institution, give street end number) 25 VANDERBILT COURT 5. Social Security Number 6. Sex 71 Yrs. 259-87-0507 Jusuat Residence of Decedent 100. Stete 10b. County 10c. Stete 10b. County 10c. Street and Number 25 VANDERBILT COURT 11. Meritel Stetus 1 Never Merried XX Merried 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 17. Father's Neme (First, Middle, Last) CHAO CHEN 19s. Informent's Neme/Reletionship (Type, Print) VENHUNG CHEN (SON) 25 VA 20b. Plece of Disposition XX Burial 2 Cremetion 3 Removet from Stete 4 Donetion 5 Other (Specify) 21. Signature of Funerel Service Limits 22. ANOREXTA Due to (or as a consect counted in death) Lest Due to (or as a consect counted in death) Lest Due to (or as a consect counted in death) Lest Due to (or as a consect counted in death) Lest Due to (or as a consect counted in death) Lest Due to (or as a consect counted in death) Lest Due to (or as a consect counted in death) Lest Due to (or as a consect counted in death) Lest	25 VANDERBILT COURT 5. Social Security Number 6. Sex 259-87-0507 Javas Residence of Decedent 10e. State 10b. County 10c. State 10b. County 10c. State 10b. County 10c. Street and Number 2.5 VANDERBILT COURT 11. Merital Status 11. Never Merried XM Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in U.S. 11. Yes, 32 XNo 11. Yes, 32 XNo 11. Yes, 32 XNo 11. Yes, 32 XNo 12. Yes Decedent Ever in U.S. 13. Was Decedent If Yes, specify 14. Yes, Gwe 15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Late the (Give kind of work. life. Do NOT use 17. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) 18. Informent's Name/Relationship (Type, Print) 19b. Mailting Address (S) VENHUNG CHEN (SON) 25 VANDERBI 20c. Method of Disposition XM Burial 2 Cremetion 3 Removet from State 4 Donation 5 Cher (Specify) 21. Signature of Funeral Service Latensian 22. Name and of the Course of Course	25 VANDERBILT COURT 7. Age (in yrs. last birthdey) 1 Under 1 Year 25 VANDERBILT COURT 7. Age (in yrs. last birthdey) 1 Under 1 Year 25 VANDERBILT 7. Age (in yrs. last birthdey) 1 Under 1 Year 25 VANDERBILT 7. Age (in yrs. last birthdey) 1 Under 1 Year 25 VANDERBILT 7. Age (in yrs. last birthdey) 1 Under 1 Year 25 VANDERBILT 7. Age (in yrs. last birthdey) 1 Under 1 Year 25 VANDERBILT 7. Age (in yrs. last birthdey) 1 Under 1 Year 25 VANDERBILT 100. City, Town or Location 1 Under 1 Year 1 Under 1 Y	4b. City, To 25 VANDERBILT COURT ROCKV	4b. City, Town, or Location 25 VANDERBILT COURT 7. Age (in yrs. last birthdey) 10 Under 1 Year 11 Under 24 Hrs. 8. 259 – 87 – 0507 1	2.5 VANDERBILT COURT 7. Age (h yrs. last birthdey) William 1. City, Town, or Location of Death 2.5 Social Security Number 6. Sex 1.2 P 7. Age (h yrs. last birthdey) William 1.0 P 1.0 P	4b. City, Town, or Location of Death 4c. Count 25 VANDERBILT COURT 7. Age (th yrs. last birthday) 1 Under 1 Vear 1 Under 24 his 8. Date of Birth 259-87-0507 100 Per 259-87-0507 1	As Eacitity Name (If not institution, give street and number) As County of Death As Cou	

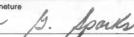
25. Was case referred to medical	28. Place of Deeth (Check only one)											
examiner? 1 Yes 20\No	Hospital:	2 ER/Outpatient	3 DOA	Other: 4 Nursing Hom	e XX Residenca	8 Other (Special						
27. Menner of Death	28a. Date of tnjury (Month, Day Yea	28b. Time of	28c. tn	jury at 2 lork?	8d. Describe how In	jury occurred						

29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Day, Year) DECEMBER 15, 1999

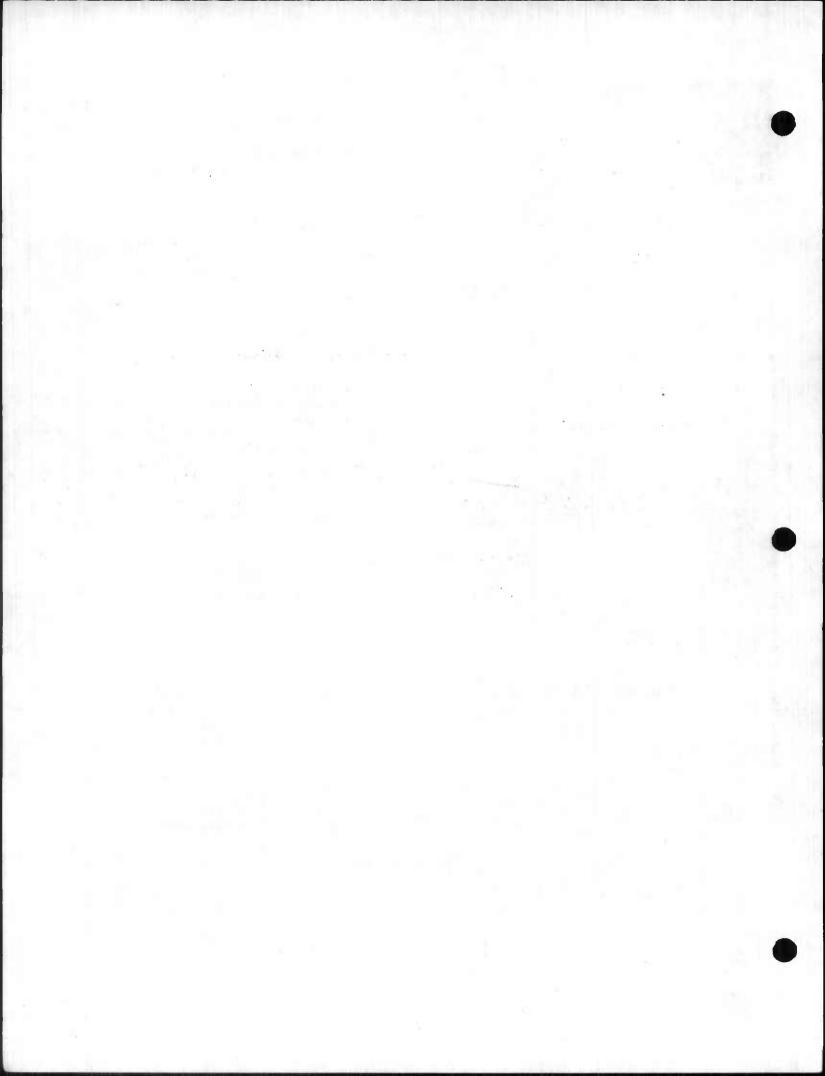
30. Name and address of person who completed cause of death (ttem 23s) (Type, Print) 20850

9707 MEDICAL CENTER DRIVE, SUITE #320, ROCKVILLE, M.D., H. VICTOR CHIANG, 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture

State Registrar



DHMH 16 Rav 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene O Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle Last) 2. Dete of Deeth Day **Physician** HELEN GERTRUDE CHRISTIAN DECEMBER 18,1999 07:40/Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY If Under 1 Yaar if Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Securify Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) **Funeral** Months Deys Hours Min. 1 M 2007 Yrs. 85 232 68 5801 Director AUG.31,1914 WEST VIRGINIA Usuel Residence of Decedent the Marylend 10e. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic event, the Madical Examinal must be notified at MD. MONTGOMERY SANDY SPRING 1 ☐ Yes 2 No Director 10e. Street and Number 17300 QUAKER LANE 10f. Zip Code 10g. Citizan of Whet Country? D - 1320860 UNITED STATES Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedant of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Sfatus Bleck, White, etc. 2 should be filed within 72 hours efter and Mental Hygiene. is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Yaer or Detes: 1 ☐ Nevar Married 2K Married 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE à 3 Widowed 4 Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Nema (First, Middle, Last) **EDMUND** HUGH BROWNING CHARLOTTE ELLEN NISBET 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2 sh Depertment of Health and Important: if item 27 ia m any injury or other traum pnce. CAROLYN C. FINEGAR, DAUGHTER 9205 ORIOLE PLACE, GAITHERSBURG, MD. 20879 20b. Plece of Disposition (Neme of cemetary, crametory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Ramoval from Stafa METROPOLITAN CREMATORY 4 ☐ Donetion 5 ☐ Other (Specify) 12/20/99 ALEXANDRIA, VA 21. Signeture of Funeral Service Licenses 22. Name and Address of Fecility
MURIEL H. BARBER FUNERAL HOME Darker P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Pert1. Enter the disease, or complications thef causad the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart fellure. List only one ceuse on each line. Approximete fnterval Between Onset and Death Physician

/Medical Examiner

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records,

or Attending Physician:

Examiner sloian and burial-trensit certificate be axecuted

physician s the burial Physiclan/Medical 88 987 à Completed director, Be 0 funeral Certification:

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efter deeth.

To the Hospital o within 24 hours of To the Funeral Di

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Medical

Immediate Ceuse (Final diseese or condition resulting in deeth) 12 HOURS . Intracerebral nemorrhage Due to (or es e consequenca of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lesf Due to (or es e consequence of): Dua fo (or as a consaquence of): 1 Yes 29 No 24e. Wes en eutopsy performed?

23b. Did tobacco use contribute to the cause of death? Pert II. Other signiffcant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 P No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No ↑ Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 5 Pending investigation Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, State) Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es stated. 29e. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or invastigetion, in my opinion, death occurred et the time, dete end plece, and due to the cause(s) end menner stated.

29b. Signatura and fifla of certifiar 29d. Date signed (Month, Dey, Year) 29c. Licanse number D23124 M.H.M

DECEMBER 18, 1999

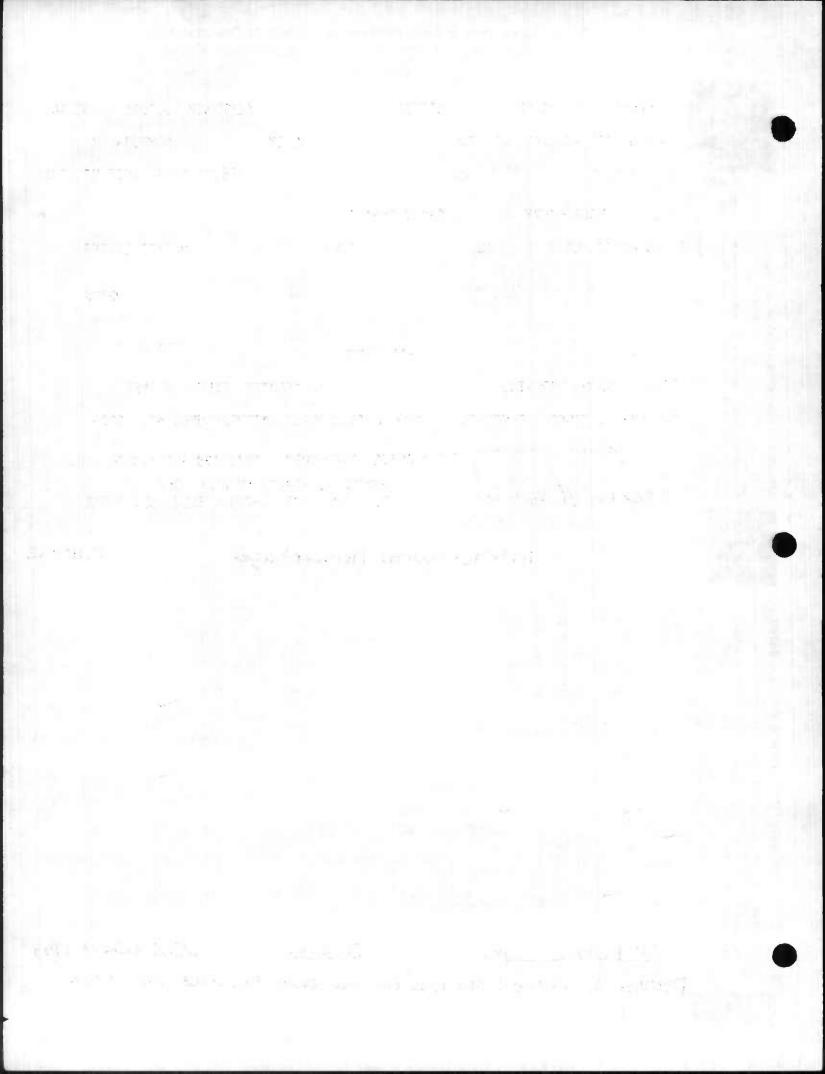
30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

1396 PICCARD DRIVE, ROCKVILLE, MD 20850 HANNON, MO DENNIS M.

State Registrar

31. Date filed (Month, Day, Year) DEC 20 1999

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month Year **Physician** 20, 8:50 AM DEC. 1999 MONNIE A. CLENDENIN /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONIGOMERY If Under 1 Year If Under 24 Hrs. Birthpleca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Days 1□M 2♥F 226-28-4147 Director VIRGINIA Usual Residance of Decedent death with the Maryland 10s State 10b Counts 10c. City, Town or Location 10d. Inside City Limits show the Medical Examiner must be nothled at 1 No Yes 2 No Director 288-1 D.C. NONE WASHINGTON 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 16th ST. N.W. #119 234 3200 20010 U.S.A. Funeral Herns : 12. Was Decedent Evar in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Bleck, White, etc. 11 Merital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Giva 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes 2 ☑ No Specify: Specify. à 3 X Widowed 4 □ Divorced WHITE Yeer or Dates: Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast greda completed) 16b. Kind of Businass/Industry Hygiena. Elementary/Secondery (0-12) College (1-4or 5+) HOUSEWIFE HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) . Pages 1 and 2 should be filt ment of Haalth and Mental Hant: If item 27 is marked oth lury or other traumatic even Be ANNIE B. W. J. GUY 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 90 LEXINGTON AVE. #10-B, NEW YORK, N.Y. 10016 GREG V. GREINER/NEPHEW 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date Important: If Its any follory or o 1 Burial 2 □ Cremation 3 □ Removal from State **Department** 4 □ Donation 5 □ Other (Specify) 12/22/99 CULPEPER NATIONAL CEM. CULPEPER, VA. 21. Signature of Funeral Service Lip 22. Name and Address of Facility M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** a ACUTERESPIRATORY FAILURE
Due to (or as a consequence of):
CONGESTIVE HEART FAILURE /Medical Immediate Causa (Fine) disease or condition resulting in death) Examiner Examiner Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the burial P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be datach 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Wes en autopsy 1 ☐ Yes 2 No 1 Yes 2 No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Investigation 1 DINatural after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C complately filled UC Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as steled.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner steled. Medical 29a. Certifier 29b. Signature and first of certifier 29c. License number 29d. Date signed (Month, Dev. Year) 3 D50821 DEC. 21, 1999 30. Nama and address of person who completed cause of deeth (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

MOFI A. WRIGHT, M.D.

DEC 22

31. Data filad (Month, Day, Year)

32. Pegistrer's Signature

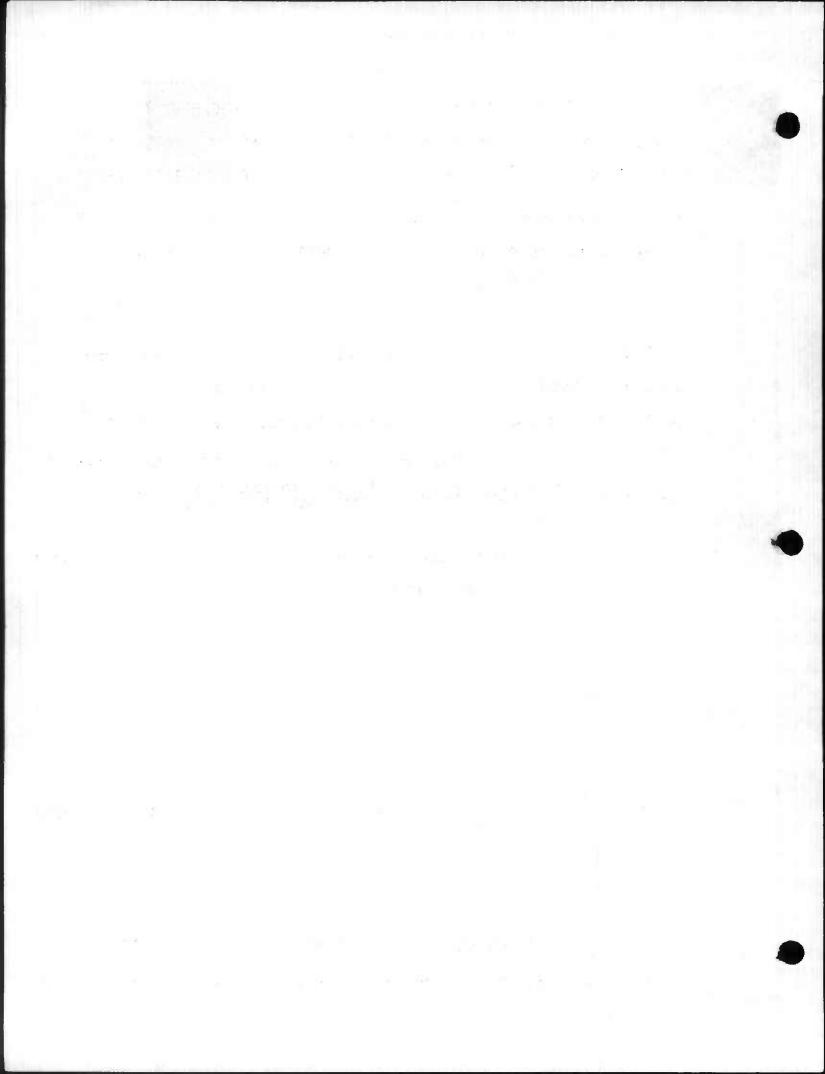
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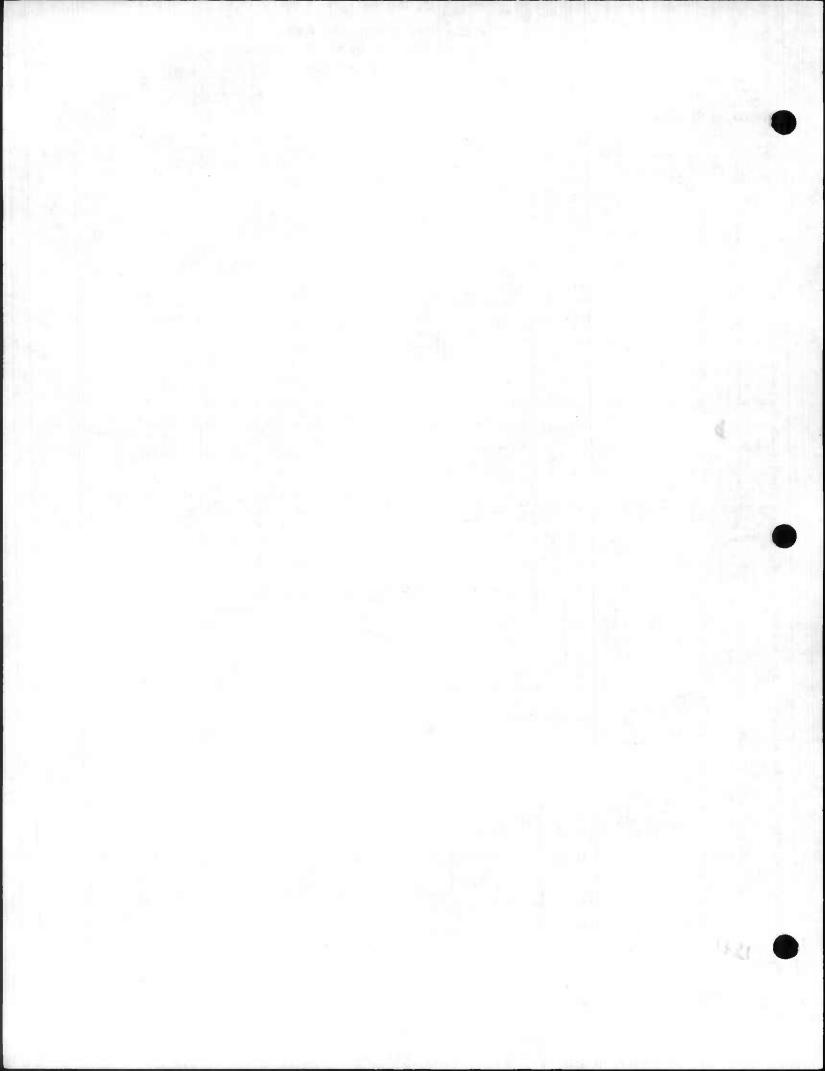


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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Date of Death Dec. 20, 1999 **Physician** Lewis C. Corbin 7:49A. /Medica 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Neme (If not institution, give street and number) **Examiner** Takoma Park Washington Adventist Hospital Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth June 20, 1932 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months 220-26-4935 1₩ M 2□ F Maryland 67 Yrs. Director Usual Residence of Decedent the Manylend 10a. Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits worle r than "natural", or items 23s or 28s-f show the Mexical Examiner must be notified at Maryland Howard Laure1 1 Yes 2 No Director 10a. Citizen of What Country? 10e, Street and Number 10f. Zip Code 8404 Cherry Laurel Court 20723 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Merital Status hours after 17 Yes 2 No If Yes, Give 1953-1961 Year or Dates: 1 Nevar Merried 20 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien important; if them 27 is marked other the any Injury or other trauments. Construction Superintendent National Applicators 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Major Lewis Corbin Florence Botler 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lee Corbin (wife) same as #10 20b. Place of Disposition (Name of cometery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Buriel 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 12/23/1999 Brentwood, Maryland 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 21. Signature of Funerel Service Licensee 4400 Powder Mill Rd. Beltsville, Maryland 20705 solowards. 23e. Part1. Enter the diseasa, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate triterval Between Onset and Death Physician Bronchogenic /Medical Immediete Cause (Finel 2 months diseasa or condition resulting in deeth) Examiner Examiner physicien end s the burial-trensit Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760. 8 Physician/Medical Due to (or as a consequence of): 88 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 No 3 Probably 4 Unknown 2 been signed to should be dete Records. by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 ☐ Yes 2 No 1 Yes 2 No certificate Division of Vital 25. Wes case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred After Attending 1 Naturel 2 Accident 5 Pending after death. 1 Yes 2 No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) n 24 hours after de sterre 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homlcide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) To the Vithin 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier Mungs und D12582 December 20, 1999 0 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) Alfred Munzer Taxoma Park, 7600 Carroll Avenue MD

DHMH 16 Rev 6/95

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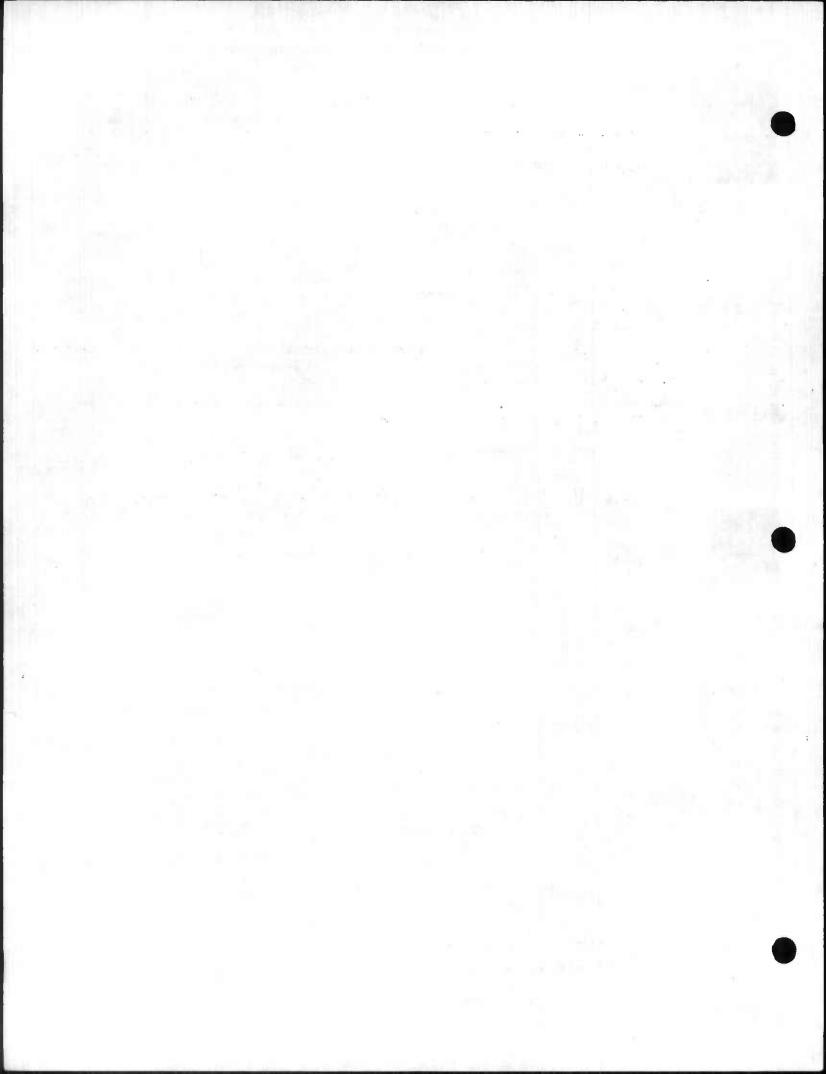
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31. Dete filed (Month, Day, Year)
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32. Registrar's Signature

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State Registrar

29b. Signatu

TOTAL Month, Day, Year) 31. D6 **DEC 2 1**

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

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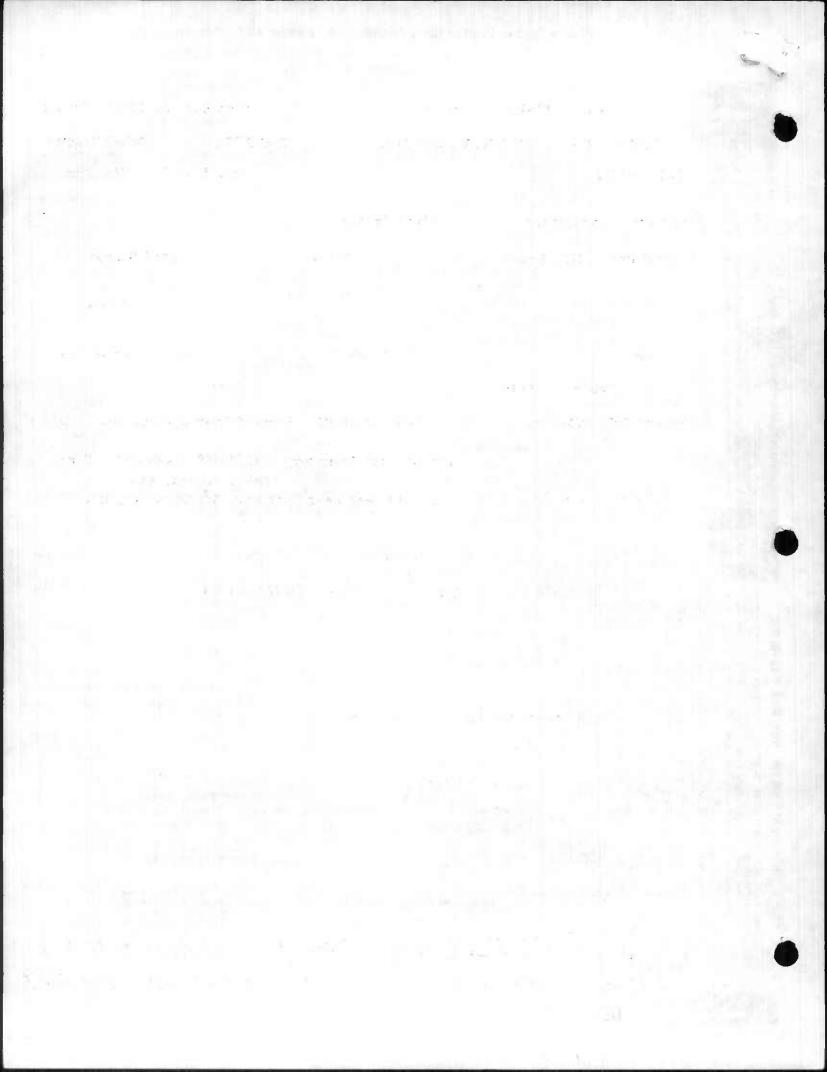
RUSSELL

29c. License number

29d. Date signed (Month, Day, Year)

GATTHEREDURO.

ecember 18,1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amended Item #26, Per Phy. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 12/22/99, Carroll County, wil 1. Decedant's Nama (First, Middle, Last) 2 Date of Death 3 Time of Death Day 1999 Month **Physician** Elsie Olivia Cooper 19, 0945 Dec /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll County General Hospital If Under 1 Year Months Days 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 28 □ F Yrs. Director 79 Mar 16,1920 213-10-5744 Maryland Usual Residence of Deceden the Maryland 10a State 10h. County 10c. City. Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23a or 28e-f show traumatic event, the Madical Examiner must be notified at Hampstead 1 ☐ Yes 2 No Director Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 4220 Lower Beckleysville Road 21074 USA Funerai death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 200 No If Yes, Giva Yaar or Dates: Was Dacedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or fler any Injury or other traumatic avena. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White p 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Nelson Tinsley Lavina Francis 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Cooper, Jr, son 427 John Owings Rd, Westminster, MD 21158 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 12/22 Baltimore, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee M00723 Eline Funeral Home 934 South Main St, Hampstead, Md 21074 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final nows disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner burial-transit certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the ettending physician d be deteched for use as the buria Records, P.O. Box 68760 Physician/Medicai Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by sate hes been sig page 2 should b 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 Yes 2 No certificate Division of Vital Attending Physician: Be 25. Was cesa referred to medicel 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: After T □ Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accidant To the Hospital or Attendition 24 hours efter deal To the Funeral Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

m n

32. Registrar's Signature

harter

completed cause of death (Item 23a) (Type, Print)

71116

and ver

3164

29d. Date signed (Month, Day, Year)

State Registrar

29b. Signature and

30. Name and address of person who

31. Date filed (Month, Day, Year)

Stevan

DEC 2 2 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** Jannie Cousar Dec. 20. 1999 11:35 P.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Hospital Ft. Washington Prince Georges If Under 1 Year If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (Stata or Foraign
Country) 7. Age (In yrs. last birthday) **Funeral** Days 249-62-0014 1 M 2 XF 90 Yrs. Director April 22,1909 South Carolina Usual Rasidence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at 1 Yas 2 No Directo S.C. Sumter Maysville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? b 22 Congress St. 29104 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U,S. Armed Forceş? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, atc. permit. Pages 1 and 2 should be tiled within 72 hours after Department of Health and Mantal Hygiene. Introcreate if item 27 is marked other than "natural", or beany injury or other traumatic. 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black À 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 4th College (1-4or 5+) At Home Housewife 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be Bristol Daniels Elizabeth McCutcheon 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 3708 Oaklawn Road Ft. Washington, Md. 20744 Joseph Daniels/Nephew 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetary, crematory or other place) Data 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State Ebenezer AME Church Cemetery 12/23/99 Sumter, S.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 tease or complication that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, urn. List only one came on each line. Approximata Intarval Batween Onset and Death **Physician** Immediata Causa (Finat disaasa or condition rasulting in death) /Medical RESPIRATORY Examiner Examiner the attending physician and hed for use es the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last VECROTIZING Box 68760. FASCHTIS Physician/Medicai Due to (or as a consequence of) 50 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? SEPSIS 1 Yea 2 No 3 Probably 4 Unknown Division of Vital Records, À 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 ☐ Yas 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: 1 Munpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 0 1 Yas 250 No 28d. Describe how injury occurred 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: Injury at Work? → / / 1 | Yas 2 | No 1 Matural
2 Accident 5 Pending invastigation NIA MIA 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one)

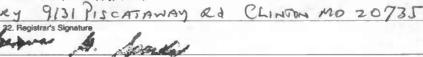
State Registrar

9/31 VICTOR E. HERRY 31. Data filed (Month, Day, Year) DEC 2 2 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J4cmy

29b. Signatura and titla of certifier



DHMH 16 Rev 6/95

29c. License number

1)20586

29d. Data signed (Month, Day, Year)

186 2 8 359 January . 3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 99 41767

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	Physic /Medi		E. Je	rone	Carter							Decem	Day ber	21	1999	061	2
	Exami		4a. Facility Neme (If not in	stitution, g	ive street end n	um <i>ber)</i>				4b. City, To	own, or L	ocation of Dea	T	County	of Deeth		
1			Casey Hou	ise						Roc	kvil	le		Mor	ntgome	erv	
Н	Funeral		5. Sociel Security Number		Sex	7. Age (/	n yrs. lest birthd	av) If	Under 1 Yaar				rth				or Foreign
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	the the	Director	Maryland 10e. Street end Numbar	Mon	tgomery		K	_	ville				40-00			Λ	-
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10	Physician		SHOOK, 9 HEER TEHRO	s. List Offi	y one cease on	eeur iii le.										ntervel Be Onset end	
	/Medical		Immediate Cause (Finai														
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Ĕ	after death after death Director: /	1	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not letermine	d 200. Piec	e of Injury ding, etc. (5	- At home, farm,	street, f	factory, office			28f. Location City or To	(Street en	d Numbe	er or Rurel I	Route Nu	m <i>ber</i> ,
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	hour hour ly fill		29e. Certifier	rtifying P	hysician: To the	e best of m	y knowledge, de	eth occ	curred et the tir	me, date er	nd plece,	end due to the	ceuse(s)	end mei	nner as stet	ted.	
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(3)		30. Name end eddress of p			ise of deeth	n (Item 23e) (Ty) 2101 M	oe, Print edic	al Par	k Dr	#2	10. 51	vor	Snrt	ino. N	MD 2	20902
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State of Maryland / Department of Health and Mental Hygiene 🍳 🤉 Certificate of Death

Hours

Physician /Medical Examiner

Thomas Stanley Childress 4a Facility Name (# not institution, give street and number)
Saint Joseph Medical Center

1. Decedent's Name (First, Middle, Last)

4b. City, Town, or Location of Death Towson

DECEMBER 16, 1999 3:25 AM 4c. County of Death Baltimore

Funeral

224-16-7010 Usual Residence of Decedent

Days Months Yrs.

If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) April 9, 1917

2. Dete of Death

9. Birthplace (State or Foreign Virginia

Director

8 238

8

Funeral

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Completed

8

2

Baltimore, Maryland

Pages 1 and 2 should be nent of Health and Mental

or other tr

Physician

/Medical Examiner

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physician s the buria

signed by the a

should I

page 2 s

director,

this funeral

death.

24 hours after deat Funeral Director:

within 2 To the

Hospital

filled in by

compietely

88 980

The lew requires that the death certificate be executed

Box 68760,

P.O.

Records,

Division of Vital or Attending Physician: Examiner

Physician/Medical

ģ

Completed

Be

9

Certification:

edical

10a. State 10b. County Baltimore 10c. City, Town or Location Baltimore

7. Age (In yrs. last birthday)

10d. Inside City Limits 1 ☐ Yes 2 ☐ No

Directo 10e. Street and Number

5. Social Security Number

10 M 2□ F

10f. Zip Code 21234 10g. Citizen of What Country? United States

8710 Emge Rd 11. Merital Status

> 1 Never Married 2 Married 3 ☐ Widowed 4 🛣 Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 Tho
If Yes, Give
Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

82

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Theodore

Childress.

Gertrude

Henley

19e. Informent's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18. Mother's Name (First, Middle, Maiden Surneme)

Douglas Childress/son

20b. Place of Disposition (Name of cemetery, crematory or other place)

Truck Driver

2701 E. Strathmore Ave Baltimore, MD 21214

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

Chesapeake Crematory

Date 20c. Location - City or Town, State 12-20-99 Beltsville, Maryland

21. Signature of Funeral 5

22. Name and Address of Fecility CAFA Stephen D. Lohnmann, P.A.

23a. Pert1. Enter the disees shock, or heart feilure.

se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest,

List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of)

PNEUMONIA

Approximate Interval Between Onset and Death 3 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco usa contribute to the cause of death? 1 Yes No 3 Probably 4 Unknown

24a. Wes en autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2⊠No

1 ☐ Yes 2K No

25. Was case referred to medical examiner? 1 Yes 2 No

5 Pending investigation

6 Could not be determined

12 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 Tyes 2 No

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

29a. Certifier (Check only one)

27. Manner of Death

1 Netural

2 Accident

3 Suicide

4 Homicide

TS Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number D 30263

29b. Signeture and title of confiden

29d. Date signed (Month, Day, Year) 12-17-99

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

State

Registrar

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
FRANCIS KHOD, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year)

DEC 2 1 1999

32. Registrar's Signature

DHMH 16 Rev 6/95

080 2 1 1999 Same

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Depart

	2. Dete of Death			3. Time	of D
rtificate of Death	Reg. No.	W. N.			
artment of Health and M	ientai Hygiene	99	Li	1 /	0

Physician /Medical **Examiner**

John C. Carr 4e Facility Neme (If not institution, give street and number)

1. Decedent's Neme (First, Middle, Last)

Month DEC. 19, 1999 4b. City, Town, or Location of Death

Nov.

3. Time of Death 0750 AM

Funeral

UNION MEMORIAL HOSPITAL E.R. 5. Sociel Security Number 7. Age (In yrs. last birthday) 10 M 2□ F

BALTIMORE If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)

Hours

N/A Birthplace (State or Foreign Country)

4c. County of Death

18,1929

Director

28a-f show

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Department o Important: If any injury or

Physician

Examiner

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physician

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page 2 should

funeral director,

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completely

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After

s after death.

24 hours a Funeral D Hospital

Within 2 95

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records.

or Attending Physician:

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

/Medical

Directo

Funeral

by

Completed

Be

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0020

Usual Residence of Decedent 10a, Stete 10b. County

10c. City. Town or Location

Washington D.C.

Months

Washington DC 10d. Inside City Limits

XXYes 2 No

N/A 10e. Street and Number

577 42 7751

2501 Calvert Street NW

N/A

20008

1 Yes 2€No Specify:

10f. Zio Code

Days

10g. Citizen of Whal Country?

11. Merifel Stefus

1XXNever Merried 2□ Merried

12. Wes Decedanf Ever in U,S. Armed Forces? 1 ☐ Yes 220No If Yes, Give Yeer or Detes:

College (1-4or 5+)

70

Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

United States 14. Rece - American Indien. Bleck, White, etc.

3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

White 16b. Kind of Business/Industry University of

Specify:

Elementery/Secondery (0-12) 12

Teacher

Maryland

17. Fathar's Name (First, Middle, Last)

William P. Carr

18. Mother's Neme (First, Middle, Meiden Sumame)

Olive Hughes

19a. Informant's Name/Ralationship (Type, Print) Susan Houle

Niece

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7915 Evesboro Drive Severn Maryland 21144

20e. Method of Disposition

1 ☐ Burial 2 € Cremetion 3 ☐ Removel from Stete 4 Donetion 5 Other (Specify)

20b. Plece of Disposition (Nama of cemetery, crematory or other place) Dec. The Huntt Crematory

23 Dete 999 20c. Location - City or Town, State Waldorf Maryland

21. Signature of Funeral Service Lin

22. Name end Address of Fecility Robert E. Evans Funeral Home, Inc.

Robert E. Evans runeral 16000 Annapolis Rd. Bowie Maryland 20715

Approximate intervel Between and D. Constant D. Constant and 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on one cause on each line.

Onset and Death

Immediete Cause (Finei diseese or condition resulting in deeth)

Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of)

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest

Dua to (or as e consequence of)

Due to (or es e consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco usa contribute to the cause of deeth?

1 Yaa 2 No 3 Probably 4 Unknown

24a. Was en autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

INSPECTION 1 ☐ Yes 3 No

1 ☐ Yes 2 ☐ No

25. Wes case retarred to medical examiner? XX Yes 2□ No

3 Suicide

4 Homicide

27. Menner of Death 5 Pending investigation XX Natural 2 Accident

6 Could not be determined

28a. Dete of Injury (Month, Dey Year)

28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury et Work? 1 Tyes 2 No

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifian (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end manner stated.

26. Place of Death (Check only ona)

29b. Signeture end title of certifier

29c. License number

29d. Dete signed (Month, Day, Year)

DEC.

19, 1999

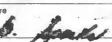
30. Name and addrass of person who complated cause of deeth (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E

31. Dete filed (Month, Day, Year) State Registrar

32. Registrar's Signeture



DHMH 16 Rev 6/95

Sec. 1 5 938

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 2 Physician 6:15 PM Ramiro G. Cintron /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner PRINCE GEORGES ar If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) HOSPITAL FORT WASHINGTON If Under 1 Yeer Birthplaca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Devs 1⊠M 2□F Months 577-40-9901 91 1908 Puerto Rico Director Usuat Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits worle 1 Yes 2 No Directo Maryland | Prince George's Colmar Manor 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20722 4318 Monroe Street United States Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 14. Raca - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Merried 2 ☐ Merried 1⊠Yes 2□No Specify: Puerto Rican Specify: Baltimore, Maryland 21215-002 by White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit Department of Heelth end Mental Hygient Important: If Nem 27 ie merited other that eny lijury or other traumatic event, trait blass. 12 4 Meteorologist United States Government 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) 8 Santiago Cintron Rosa Gallisa 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Carmen Cintron /Granddaughter 4002 Oliver Street, Hyattsville, Maryland 20782 20b. Ptece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 12-18-99Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signeture of Funeral Service/Liberto 22. Name end Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, Maryland 20722 alusor 130 6 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** gasteronlestia Blues /Medical Immediete Cause (Finel disease or condition resulting in death) Examiner Due to (or as a consequence of): of Prostate Examine physicien and s the buriel-transit certificate be assecuted Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): feeding tal. SIP gastrasley 68760 Physician/Medical Due to (or es a consequence of): Box The lew requires that the death Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? o 1 Yes 2 No 3 Probably 4 Unknown CH Frada H,C þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 8 26. Place of Death (Check only one) 1 Yes 2 No Hospitet: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Naturat 5 Pending investigation after death.

I Director: Aft
of in by the fur 1 | Yes 2 | No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 6 Could not be determined 3 Suicide 28e. Ptece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify)

م Records, of Vital Division Attanding 0 Hospital of 24 hours a Fumeral District To the P Within 2 To the P complet

> State Registrar

edical

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

DEC 2 1 1999

29a. Certifier

DECEMBER 13,1

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SE. S-#202 WASHINGTON, DC 20032 1328 SOUTHERN AUE. 31. Date fited (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

225640

32. Registrar's Signeture

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician Alectical Examiner 4. Facility Name and Provided County Town August 100 County T					Certifica	te of D	Death	Re	eg. No.		
## Scaley Name (from Institution, pie wares and number) ## Scaley Name (from Institution) ## Scaley Name (from Institut	Physician			10+10=/				Month	Day ,		3. Time of Deat
33.25 Divided Till Control Con	/Medical	4a Facility Name (If not institution, g	ive street and number			41		Location of Death		-	1000
To the processor of the control of t	Lammer	3333 UNIVERSITY 8	LUD. WOST								,
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Mary Land Montgomery Mary Land Montgomery Mary Land Montgomery Mary Land Montgomery Montgom	W H			10c. City, To	wn or Location					10	d. Inside City Lin
Market Salaus Table Deposite Five in U.S. 13. West Decodered Five in U.S. 14. Race - American Indian. 12. Part Market Salaus 12. Part Market Salaus 13. West Decodered Five in U.S. 14. Reserved Fiv	8a-f s ottling		ery	Kens							1X Yes 2
12 Martial Statum 12 Web Decedent Ever in U.S. Appendix of Fiscan More Process 14 Recent American Indian, Place 15 Recent Indian, Place 1			D1d U	# 1010	101. 2		0.5	1			y?
Specific	ms 2 cmus		12. Wes Deceden	t Ever in U.S.	13. Wes Dec			pecify Yes or No-	14. Rac	e - Americe	
Will B. Courtney 198. Mailing Address (Street and Number of Paul Rouse Number, City or Town, State, 2p Code)	ir.o	3 ₩idowed 4 □ Divorced	1 Yes 2□	No		37		o nicen, etc.)		1:	
WILL B. Courtney The Informative Name Relationship (Type, Print) The Mailing Address (Street and Number or Rural Pouts Number, City or Town, State, 2p Code) Don Zimmerman The Burning 2 Description (Name of L. 1) The Burning 2 Description (Name of Description) The Burning 2 Descripti	dical	15. Decedent's I (Specify only highest g	Education rade completed)	16	B. Decedent's Us (Give kind of w	ual Occupa vork done d	tion uring most of wo	rking	16b. Kind of Bu	usiness/Indu	stry
Will B. Courtney 198. Mailing Address (Street and Number of Paul Rouse Number, City or Town, State, 2p Code)	than the Mo	Elementary/Secondary (0-12)	College (1-4or						A . D . 7	r. Sec	urity
Will B. Courtney 198. Mailing Address (Street and Number or Rural Poute Number, City or Town, State, 2p Code)	other sent, 1	17. Father's Name (First, Middle, Las	it)		nstatter			me (First, Middle, A			urrey
Don Zimmerman 200. Mathod of Disposition 200. Flace of Disposition (Name of Pales) 200. Place of Disposition	989 0	Will B. Courtne	ey				Grace 1	Rodda			
20a. Method of Disposition 20c Place of Dispos	and la ma	19s. Informant's Name/Relationship	(Type, Print)	19	b. Mailing Addre	ss (Street a	nd Number or R	ural Route Number	, City or Town,	State, Zip (Code)
Sequentially list conditions	health m 27 mer ta		(Nephe	w) 1	4825 Pra	tt St	. Upper	Marlboro	MD 20)773 City or Tow	m Stete
22. Name and Address of Facility Rendon/Halle Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706 Annapolis Rd. Lanham,	日本の	1 \$ Burial 2 ☐ Cremation 3		cemet	ery, crematory or	other place	9)				
9013 Annapolis Rd. Lanham, Maryland 20706 Approximately sold anniner state of the second seco	infur a			ceua					Sultia	IU , III	,
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The state of the s		Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury	b	Due to (or es a	a consequence o	f):					
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25. Was cese referred to medicel examiner? 26. Place of Death (Check only one)	page om							1 🗆 Y	es 200	1 🗆	Yes 2 No
27. Manner of Death 1		25. Was cese referred to medicel examiner?	442-20-1			100		ath (Check only on	99)		
29e. Certifier (Check on one) 29e. Certifier (Check one) 29e. To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) end manner es steted. 29e. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner es steted. 29e. Signature and title of certifier 29e. Signature and title of certifier 29e. License number 29d. Date signed (Month, Day, Year)	T di	12 Yes 2 No 27. Manner of Death	1 Linpa		. Time of Injury	28c. Injury Work	et ?	-)
29e. Certifier (Check Poly one)	# # E	2 Accident investigati 3 Suicide 6 Could not	be 28e. Place of I	njury - At home, etc. (Specify)			res 2 No			ber or Rural	Route Number,
mp. (ONE) 015236 VECONGOR NO, 1900	24 hours Funeral letely fille	(Check poly 2 Medical Ex	aminer: On the basis	of examinetion a	ge, death occurre and/or investigetion	ed at the time on, in my op	e, dete end plec pinion, death occ	e, and due to the curred et the time, d	euse(s) end ma ate end piece,	anner es ste and due to	eted. the ceuse(s)
115 L56 LECENBOL 10, 1400	within comp	29b. Signature and title of certifier	100 Lo	1	-1 2						
(7) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1	-ma	COWE	J	01	2.536		pconga	1 10	, 19.00
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CALL MARGOLS, NO INVS DOCK JUST PIKE, POCKVIUS, MO VORSL	10)		o completed cause of	death (Item 23a	(Type, Print)	c5, A	arcill	5, MO 1	PS		

DHMH 16 Ray 6/95

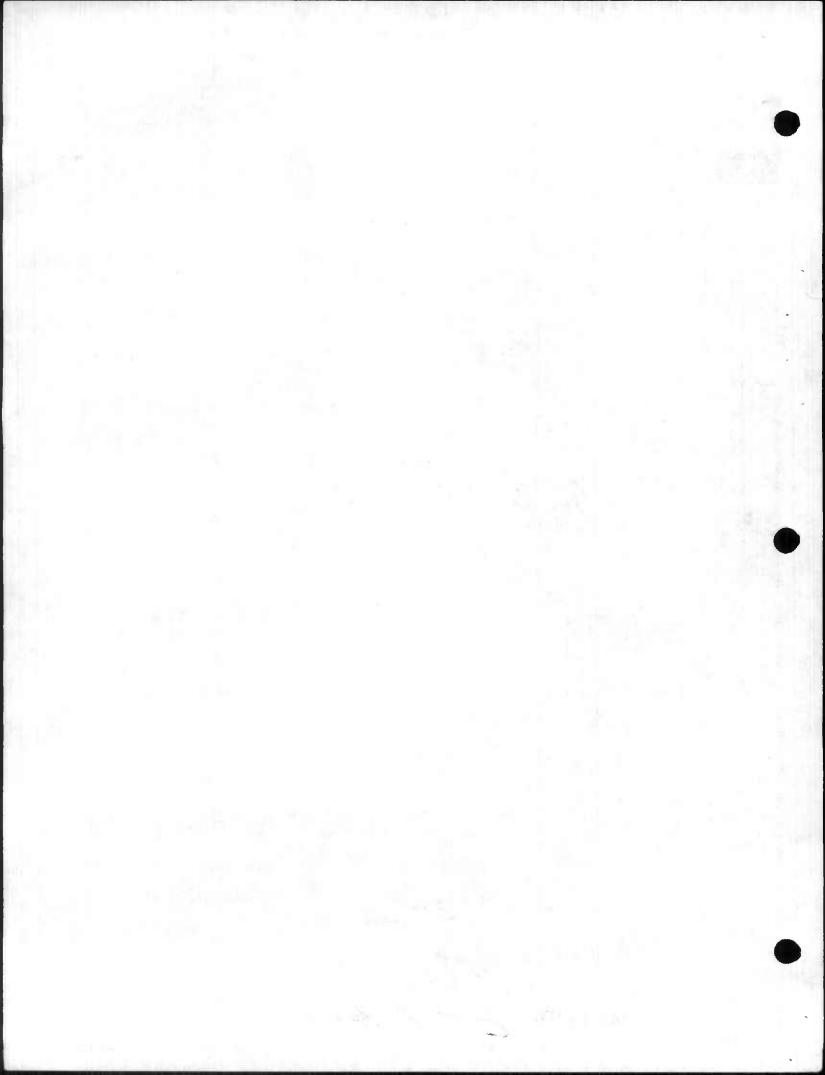
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of Maryland	d / Department of Health and Mental Hygiene	99	4	7	7:
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al er	4a Facility Nama (If not institu EASTON MEMO)	ution, giva stre RIAL HC	et and num	nber)				4b. City, To		ocation of Death	4c. County		201 212
	5. Sociel Security Number	6. Sex		7. Aga (In yrs. I	lest hirthday	tf Under	1 Yaar	If Undar		8. Dete of Birth			ace (State or Foreign
	213-80-8780		2□ F	38	Yrs.	Months	Deys	Hours	Min.	8. Dete of Birth (Month, Day, JULY 19	Year) 1961	MAR	ace (Stete or Foreign try) YLAND
	Usuel Residence of Deceden												
	10a. Stete 10b. Cou			10c. City	y, Town or L							10	Od. Inside City Limits 1 ☑ Yas 2 ☐ No
		AROLINI	E		RIDO	7							
	10e. Street and Number 502 CENTRA	T AVENI	IIC			10f. Zip		660		1	0g. Citizen of V		
	11. Marital Status			dent Ever In U,	S 13	Was Dece		660 dispanic Ori	igin? (Sp	ecify Yas or No-	14. Reci	USA a - America	
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	3 ☐ Widowed 4\OxDivor		If Yes, Give Year or De	a		1 Yas	2XXVo	Specify:			Specify	:	WHITE
	15. Dece (Specify only hi	dent's Educati	lon om oleted)		16a. Dece	dent's Usua	l Occup	ation during mos	t of work	ina	16b. Kind of Bu	siness/Inc	lustry
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1	17. Father's Neme (First, Mid ROBERT LYNWO		SDEN							e (First, Middle, M		0)	
1	19e. Informent's Neme/Relet				10h Maii	na Address	(Street			ral Route Number		State Zin	Code)
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	1 Buriel 2XX remeti		ovel from S	STATA	emetery, cre SAPEAR				TR.	12-28-99	CHEST	ER. M	D
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	23a Perf1. Enter the disease shock, or heart failure.	o Complicet	ions that ca	aused the death	n. Do not en	ter the mod	e of dyir	ng, such as	cardiec	• EASTON or raspiratory arm	est,	001	Approximete Interval Between
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1													mpletion of cause death?
										NOV	es 2 No	1)	Yes 2□ No
	25. Wes case referred to med exeminer?								e of Dea	th (Check only or	16)		
-	Yes 2□ No	Hos	1 🗆 Ir		XR/Outpatie		/A		ursing He	ome 5 ☐ Reside			y)
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	2 ☐ Accident inv	astigetion		1100		M		Yes 2	No	20f Location (C	traat and blumb	or or P.	I Poute Number
		termined	28e. Placa buildin	of tnjury - At ho ng, etc. (Specif)	om <i>e</i> , ferm, si	reet, fector	, offica			City or Town	n, State)	er or Mura	I Route Number,
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	29a. Certifier 1 Certifier (Check only one)	irying Physici Icat Examiner:	en: To the la : On the ba end menn	sis of examinat	wieuge, deel tion and/or in	vestigation	, in my o	opinion, de	eth occur	end due to the c red at the time, d	late and place,	and due to	the cause(s)
	29b. Signatura and title of cer	rtifier	STO MOUNT			29	. Licens	sa number		2	9d. Data signe	d (Month,	Day, Year)
	VTV 0	1 11	1/.	0/ -			0.0	C.M.E	•		DECEMBE	ER 26	, 1999
	30. Name and address of per	son who come	leted cause	a 61 ddath (Item	23a) (Type	Print)							
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	(70000)	6 Me	Kiry	AAL.	- cuii	, LL CC	., D	от с щ()	OTG,	LIGITATE	M 2120.	L	

DHMH 16 Rsv 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First Middle Last) 2. Data of Death December 19, 1999 Currie

3. Time of Death

9. Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 □ No

20744

20747

Approximata Interval Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

29d. Date signed (Month, Day, Year)

CLINTON

10:10pm

Physician /Medical Examiner

Funeral Director

"natural", or itema 23a or 28a-f show idical Examiner must be notified at permit. Peges 1 and 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or ite each Injury or other traumatic event, or Medical Examina Dates.

3altimore, Maryland 21215-0020

Physician /Medical **Examiner**

The law requires that the death certificets be executed P.O. Box 68760, the Records, Division of Vital or Attending Physician: After this

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital \$ 0 Registrar

James Arthur 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days 1⊠M 2□ F Yrs. 241-40-0895 68 July 16, 1931 Lumberton, N.C. Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location Director Maryland Prince George's Ft. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6913 Calvin St. 20744 Funeral United States Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ⊠ Yas 2 □ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Specify: Black 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) P.G. Board of Education Administrator 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be James Currie, Sr. Lena Taylor Lo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6913 Calvin St. FT. Washington, Maryland 2 of Disposition (Name of Date 20c. Location - City or Town, State Hortense Q. Currie/Wife 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 1 ₺ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata Maryland National Cem. 12/27/99 Laurel, Md. 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility
Alexander S. Pope Funeral Homes 21. Signature of Funaral Sarvice Licensee 9110 5538 Marlboro Pike/Forestville, Md. 23a. Part1. Enlar the disease, or combinations that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediata Causa (Final disaasa or condition resulting in deeth) MLURE ENAZ Due to (or as a consequence of): Physician/Medical Examiner PTIC E Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or es e consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? AS PIRATION 1 Yes 2 No 3 Probably 4 Unknown NSUMONIA p Completed 24a. Was an autoosy 1 ☐ Yes 2 No 25. Wes casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 ☐ Yas 2 No 1 ☑(Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No invastigation 2 Accident 6 Could not be 3 Suicida 28a. Place of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homlcide 1 Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e, Cartifiar (Check only

& VENKAT. S. 31. Data liled (Month, Day, Year) DEC 2 3 1999

MA

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

KAMANAN

29b. Signature and title of/orintier

7501 32, Registrar's Signatura

29c. License number

3885

307

345 1 1 346

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedant's Nama (First, Middle, Last) 2. Date of Death **Physician** Walter Emerson Daniels December 15, 1999 4:10 PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL | If Under 1 Year SHADY GROVE ADVENTIST ROCKVILLE
W Under 24 Hrs. | 8 Date MONTGOMERY 5. Social Security Number 7. Age (In vrs. last birthday) 8. Data of Birth (Month, Day, Year) April 20, Birthplace (State or Foreign Country) **Funeral** Months Days Min. Hours 74 Director 216-16-5960 1925 Baltimore, Usual Rasidence of Decedent 10a Stata 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 Yes 2 No Directo Union Parish Farmerville. 280-7 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? ò 109 Sarah Lane 238 71241 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
120 Kes 2 Do 194
17 Ves, Give
Year or Dates: 194 Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Statue 14. Race - American Indian. Black, Whita, etc. 1943 1 Never Married 2 Married 8 1 Yes 2 No Specify: Specify: White à 3XIWidowed 4 □ Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Layout Worker Steel Contruction permit. Pages 1 and 2 should be fire Department of Health and Mental Hy Important: if them 27 is merised othe any injury or other traumetic event app. 17. Fathar's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be John Walter Daniels Mary Ella Smith 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dillard Pilgreen - Friend 109 Sarah Lane, Farmerville, LA 71241 20a. Mathod of Disposition 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State Data Burial 2 Cramation 3 Removal from State 12/23 Mulhearn Memorial Park Cemetery 1999 4 ☐ Donation 5 ☐ Othar (Specify) Monroe, LA 21. Signature of Funaral Service Licenses 22. Name and Address of Facility Metropolitan Funeral Service, Inc 5517 Vine Street, Alexandria, VA 22310 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one-cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final INTRACEREBRAL HEMORRHAGE disaasa or condition resulting in daath) Examiner Examiner ATRIAL FIRRILLA TION Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Ceuse (Disaase or injury that initiated evants rasulting in daath) Last The law requires that the death certificate be execu Physician/Medical the Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 1€ No 1 Yes 2 10 25. Was casa refarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 100 Certification: To 12 Inpatient 2 ER/Outpatient 3 DOA this 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? After or Attanding 1 Natural 5 Pending Invastigation death. 1 Tyes 2 No s after death 2 Accident 6 Could not be datermined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) in by 4 ☐ Homicida within 24 hours a To the Funeral L Hospitai 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one)

State Registrar

2

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Division of Vital Records,

DEC 22 1999

29b. Signatura and titla of certifier

31. Data filad (Month, Day, Year)

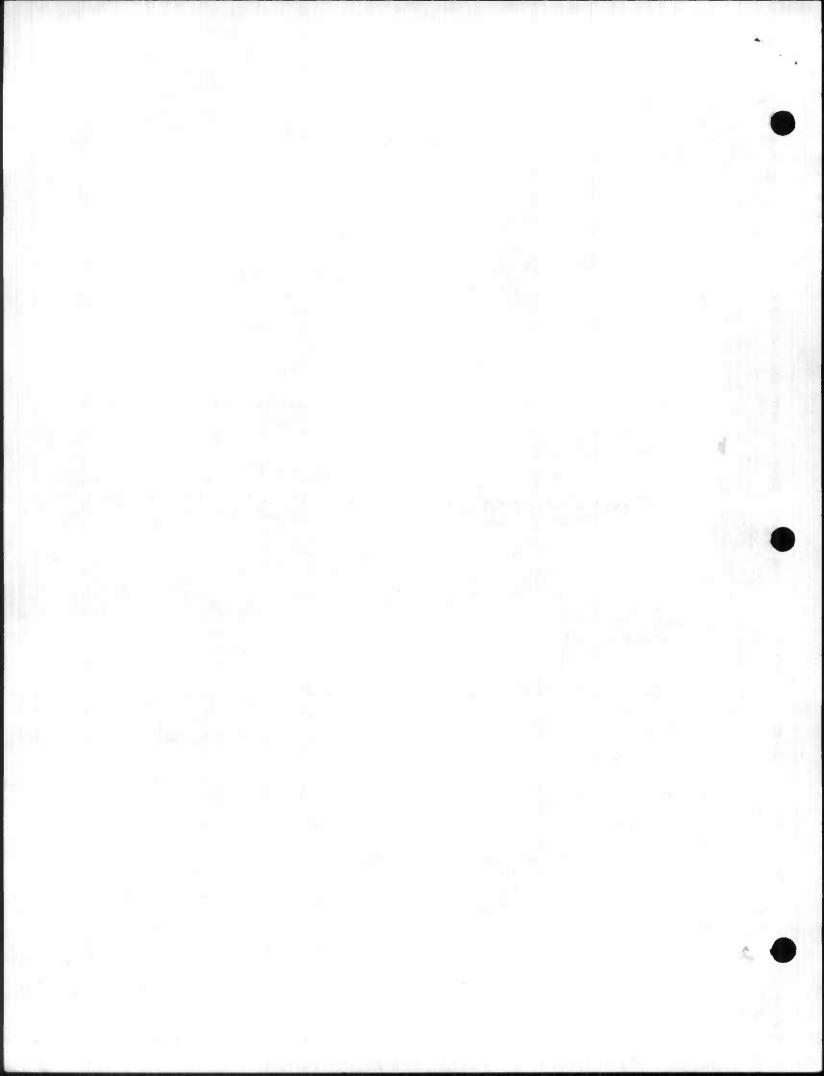
11125 ROCKVILLE PIKE, #208, ROCKVILLE, MD 20852 P. KURUVILLA , M.D 32 Registrar's Signature oaks

ATIT P. KURWILLA, M.D

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

046187



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene | Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** ARLEEN DARBY DECEMBER 21,1999 7:15 PM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner WILSON HEALTH CARE GAITHERSBURG MONTGOMERY If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) 101 Yrs. 5. Sociel Security Number Birthplece (State or Foreign Country) **Funeral** Months 218 56 9764 1 M 2 F Director MAY 5,1898 VIRGINIA Usuel Residence of Decedent the Meryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Heelth and Mental Hygiene. Important: if Item 27 is merked other than "natural", or items 23s or 28s-f show any injury or other traumstic event, the Mexical Examines must be notified as MD. MONTGOMERY GAITHERSBURG 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10a. Citizen of Whet Country? 20878 UNITED STATES 17716 PARKRIDGE DRIVE Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus Bleck, White, etc. 1 □ Never Merried 2 □ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE by 3⊠Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Be BYRON JOHNSTON NANNIE KELLER 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 17716 PARKRIDGE DRIVE, GAITHERSBURG, MD. 20878 NANCY D. SWOPE, DAUGHTER 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 12/23/99 MONOCACY CEMETERY BEALLSVILLE, MD. 22. Name and Address of Fecility
MURIEL H. BARBER FUNERAL HOME 21. Signeture of Funerel Servica Licensee muruel Bark P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examiner physician and the burief-frensit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use confribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? certificate has 1 Yes 2 4No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours efter deeth.

To the Funeral Director: After this certifica 25. Wes case referred to medical exeminer?

1 Yes 2 No Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) 28c. Injury et Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end menner steted. 29a. Certifier Medical (Check only one) 29d. Dete signed (Month, Day, Year) 29c. License number 29b. Signeture end title of certifier 5 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DR. H. ROBERT BIRSCHBACH, 6320 DEMOCRACY BLVD

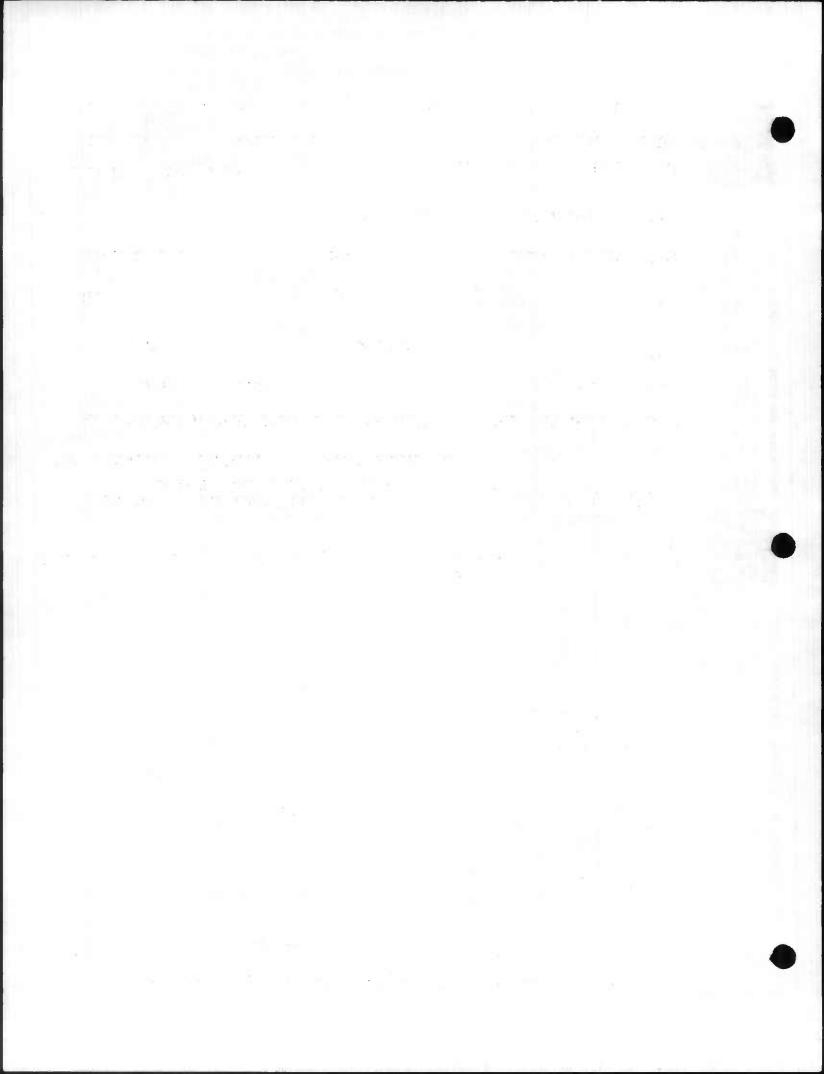
32. Registrer's Signeture

BETHESDA, MD. 20817

DHMH 16 Rev 6/95

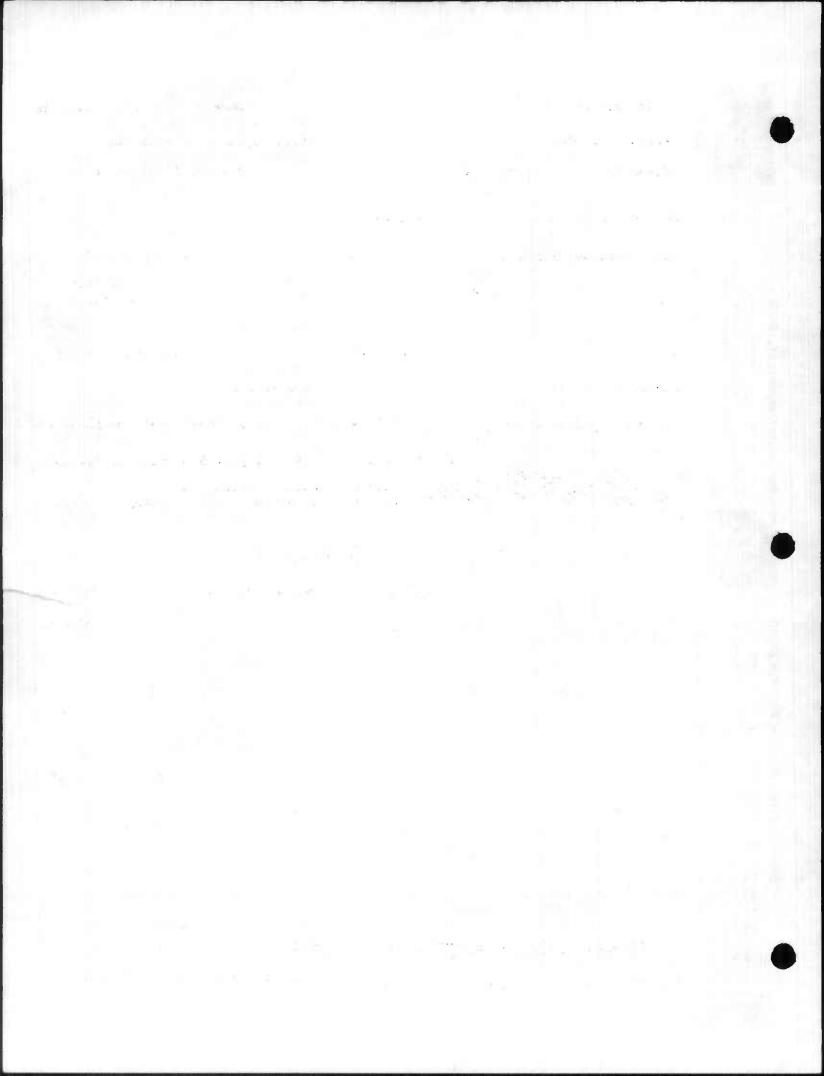
State Registrar 31. Dete filed (Month, Day, Year)

DEC 23



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	Certificate of Death		leg. No.	771770
Physician		2. Dete of Dee Month	Dey Yee	
/Medical			er 15, 199	
Examiner	4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Loc Woodside Center Silver Sp			
Suggest			Montgom	Sirthplece (Stete or Foreign Country)
Funeral Director	578-62-3284 1 M 2 F 89 Yrs. Months Days Hours Min.	8. Dete of Birth (Month, Dey May 17,	1910 II	linois
72 hours after death with the Maryland natural; or items 23s or 28s-f show often Examines must be notified at seed by Funeral Director	10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits 1X Yes 2 □ No
or 28a-f a	Maryland Montgomery Chevy Chase			
Direct Di	10e. Street end Number 10f. Zip Code		10g. Citizen of Whet	
erai	3316 Brooklawn Terrace 20815 11. Marital Status 12. Wes Decedent Ever in U.S. 13. Was Decedent of Hispenic Origin? (Spec	cify Yes or No-	United St	maricen Indien,
al', or items 23a or 28a-f ahow Examiner must be notified at by Funeral Director	11. Marital Status 1 □ Never Merried 2 □ Merried 1 □ Never Merried 2 □ Merried 2 □ Merried 3 □ Widowed 4 □ Divorced 12. Wes Decedent Ever in U,S. Armed Forcas? 1 □ Yas 2 □ No If Yes, Give Yaar or Detes: 13. Was Decedent of Hispenic Origin? (Specify Cuban, Mexican, Puerto Forcas) 1 □ Yes, Specify: 1 □ Yes 2 □ No	Rican, etc.)	A	frican - erican
t, the Medical Exa Completed by	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of workin life. DO NOT use retired)	9	16b. Kind of Busines	ss/Industry
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event, Be C	17. Fether's Neme (First, Middle, Last) 18. Mother's Neme	(First, Middle,		
	Albert J. Carter Maggie C	hiles		
r is marked other traumatic event, it To Be Co	19e. Informent's Name/Reletionship (Type, Print) 19b. Malling Address (Street end Number or Rural			
CI -	Margo D. Pinson, daughter 3316 Brooklawn Terrace			
If itam 2 or other	20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece)	Dete	20c. Location - City	or Town, Stata
in in	4 Donetion 5 Other (Specify) Ft. Lincoln Cemetery 12	/20/99	Brentwood	, Maryland
sician edical	McGuire Funeral Service (Finel Service) McGuire Funeral Service (Finel Service) McGuire Funeral Service (Finel Service) Avenue No not enter the mode of dying, such as cerdiac or shock, or heart fellure. List only one ceuse on each line.	, N.W.,	Washingt	Approximete Intervel Between Onset end Death
niner	Immediate Ceuse (Finel disease or condition resulting in deeth) e. Respiratory failure pue to (or es e consequence of):			1 day
the burial-transit	Sequentially list conditions b. Aspralian Pnell nut Que to (or es e consequence of):	me		Iweek
	if eny, leeding to immediate cause. Enter Underlying			Lupa
s the bu	Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Dua to (or as a consaquenca of):			June
	d			
d for a	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I.	23h Did t	obacco use contribu	uts to the causs of death?
be detached for use to by Physician/M	Path. Other significant conditions contributing to death but not resolving in the underlying cause given in Pert i.			Probably 42 Unknown
2 should		24e. Wes perfor	an autopsy 24 med?	b. Were autopsy findings aveilable prior to completion of cause of death?
Page		1 🗆 Y	es 2 KNo	1 ☐ Yes 22 No
rector, pag	25. Wes cese referred to medical exeminer?	(Check only o	ne)	1
T di di			lence 8 Other (S	pecify)
funer tion:	1 Neturel 5 Pending (Month, Dey Year) Injury Work?	od. Describe n	ow injury occurred	
y tha	2 Accident	28f. Location (5 City or Tow		Rural Route Number,
Medical Certi	29a. Certifier (Check only one) Cartifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, e Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred and manner stated.	and due to the o	ceuse(s) end menner dete end place, end d	es steted. due to the ceuse(s)
Ne Me	29b. Signature and titla of certifiar 29c. Licensa number		29d. Dete signed (Mo	onth, Dey, Year)
,	I Amendlusello ND D38262		Decembe	121, 1999
	Jone and eddress of person who completed ceuse of deeth (Item 23e) (Type, Print) Dr Mendhiratta 2401 Research BLVD Suite	340 R	Eo cturlls	LWD 20850
State	31. Dete filed (Month, Day, Yeer) 32. Registrer's Signeture			
Registrar	31. Dete filed (Month, Day, Yeer) DEC 22 1999 32. Degistrer's Signeture . Spark			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month DEC. 1999 TATIANA Ζ. DIAZ 16, 1341 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) Months 2 Days 28 Hours 1 M 2 XF MONE Sept. 18, 1999 Maryland Usual Residence of Dacedant 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19352 Circle Gate Drive, #103 20874 U.S.A. 14. Race - American Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Never Married 2 Married 1 Yas 2 No Specify: Black 1 Yas 2 No Specify: 3 Widowed 4 Divorced Yaer or Datas: 15. Decedent's Education (Specify only highast grads completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 18. Mother's Name (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Tony Diaz Monique Wongus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 20874 Monique Wongus (Mother) 19352 Circle Gate Dr., Germantown, MD 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal Irom Stata Gate of Heaven Cem. 12/20/99 4 □ Donation 5 □ Other (Specify) 22. Nama and Address of Facility SNOWDEN FUNERAL HOME, P.A. Silver Spring, MD 21. Signature of Furieral Sarvice License 23a. Part1. Enter the dijaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haar lajfura. List only one cause on each line. Approximete Intervat Between Onset and Death Immediate Causa (Final Cardiac arrest diseasa or condition resulting in deeth) Due to (or es a consequence of): Status post Truncus arteriosus repair Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

physician

has

certificate

this After

24 hours after death.

Funeral Director: A 3

within 2.

tilled in

completely

Medical

The law requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

or Attending Physician:

Hospital

Physician

Examiner

Funeral

Director

28a-fi

must be r

The Maryland

filed within 72 hours effer

Hygiene.

Pages 1 and 2 should be fit ment of Health and Mental H and: If them 27 is marked oth lury or other traumatic even

Department o Important: If I any Injury or

Baltimore, Maryland 21215-0020

/Medical

Director

Funeral

'n

Completed

Be

MD

Examiner burial-transit Physician/Medical the 88 980 jo signed by the a Completed by page 2 funeral director, Be Certification: To

Sequentially list conditions, if any, laading to immadiate cause. Enter Undarlying Causa (Disease or injury that initiated avants resulting in death) Last

Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.

24a. Wes an autopsy performed?

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No

1 ☐ Yas 2 ☐ No

29.	. TVas Casa rararre	d to medical					26. Place of De	eth (C	neck only one)	
	axaminar? 1 ☐ Yes 2∑ N	lo	Hospital: 1 ☐ Inpatient 2 🔀	ER/Outpatient	3□	DOA Other	4 Nursing	Homa	5 Residence	6 □Other (Specify)
27.	Mannar of Death Natural Control Control	5 Pending investigation		28b. Tima of Injury	М	28c. Injury Work			. Describe how inj	
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be detarmined	28a. Place of Injury - At h building, etc. (Speci	noma, farm, stree	t, lact	ory, office			Location (Street a City or Town, Sta	and Number or Rural Route te)

29e. Cartifian (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and fille of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D51927 Dec. 16, 1999

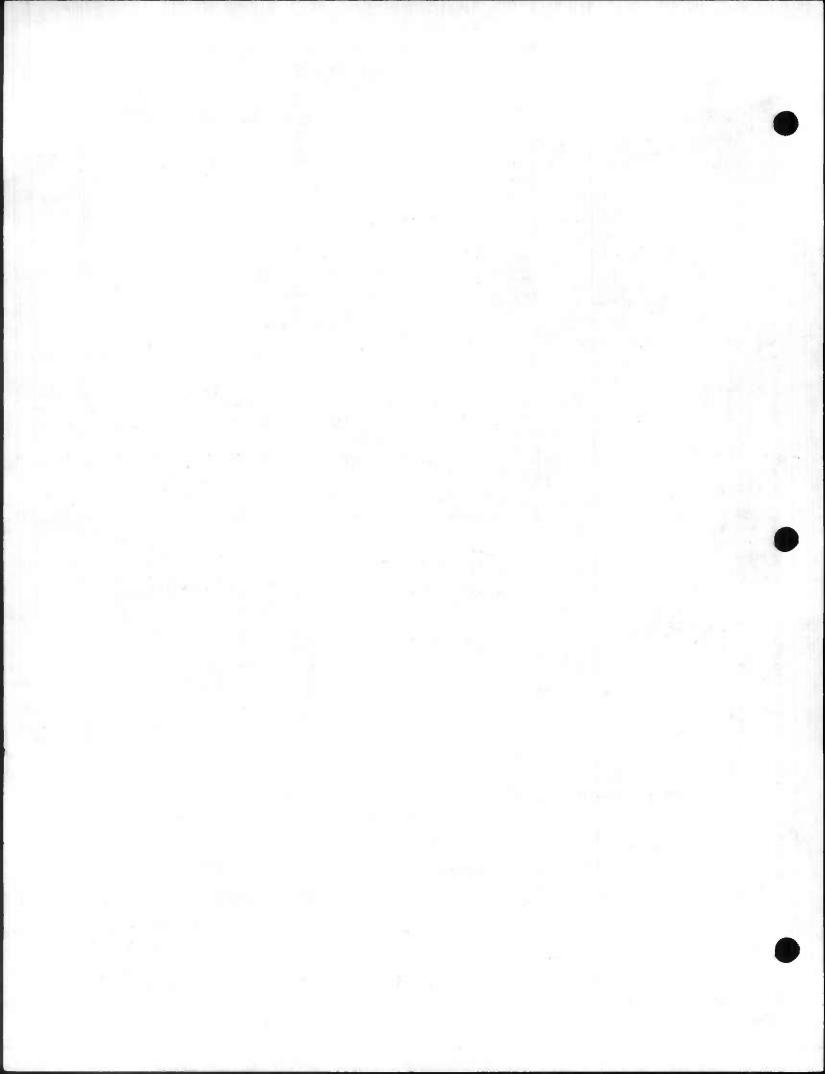
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dawn Thornton, M.D. 9901 Medical Center Dr., Rockville, MD 20850 31. Data liled (Mooth, Day, Year)

State Registrar

32. Registrar's Signatura 1999

Dacker



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 41778

			Ce	rtificate of	Death		Reg. No.	
Physician	Decedent's Neme (First, Middle, I			7-11		2. Date of De	ath	3. Time of Death 6:00 A
/Medical		BELLE DIX	ON					
Examiner	4e Facility Neme (If not institution, g				4b. City, Town, or		,	of Death FGOMERY
	Manor Care H			If Under 1 Yea		Sprin		
neral ector	5. Social Security Number 579-28-1978 Usual Residence of Decedent	A COLA SHEETE	(In yrs. last birthday)	Months Dey:		8. Date of Bir (Month, De July1	8,1912	9. Birthplace (State or Foreign Country) Georgia
	10a. Stete 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
tor	MD Montg	omery	Kensin	gton				1 Yes 2 □ No
al Director	10e. Street and Number 10920 Connec	ticut Ave	•	10f. Zip Code 2 (895		10g. Citizen of V	
by Funeral Director	11. Meritel Status 1 □ Never Merried 2 □ Merried 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 20 No If Yes, Give Yeer or Detes:		Was Decedent of It Yes, specify Cu 1 ☐ Yes 2 ☐XNo	Hispanlc Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No to Rican, etc.)	100000000000000000000000000000000000000	e - American Indien, sk, White, etc. r: Black
Completed	15. Decedent's (Specify only highest of	Education grade completed)	(Give	dent's Usuel Occi	e during most of wor	rking	16b. Kind of Bu	usiness/Industry
du	Elementary/Secondery (0-12)	College (1-4or 5+		DO NOT use retir airdres			Beaut	v Shop
ő	17. Father's Neme (First, Middle, La.	st)		4114161		me (First, Middle	Maiden Suman	2
To Be	John Jenkin				Geo	rgia Ma	ae Bose	eman
5	19e. Intorment's Neme/Reletionship	(Type, Print)	19b. Meili	ng Address (Stree	et end Number or Ru	urel Route Numb	er, City or Town,	Stete, Zip Code)
	Dorothy Dixon	(Daughter	241	0 20th	St., NW	, Wash	ington,	DC 20009
	20e. Method of Disposition		20b. Pleca ot Dispo cemetery, cre	osition (Name of matory or other pi	(ece)	Date	20c. Location -	City or Town, Stete
	1 Buriel 2X Cremetion 3 4 Donetion 5 Other (Spec		Metropo	litan E	/Serv l	2/19/9	9 Alexa	andria, VA
and a	21. Signature of Funeral Service Lic	K. Jusi			ress of Facility FUNERA LLE, MD	L HOME 20850	, P.A.	
	23e. Pert1. Enter the disease, or co shock, or heert tailure. List on	mplicetions thet caused the	ne deeth. Do not en	ter the mode of dy	ying, such es cardia	c or respiratory e	rrest,	Approximete the three Between
ian cal ner	Immediate Cause (Finel disease or condition resulting in death)	CERE		CULA			Τ	5 MAYS
Examiner	Samuel Market and Market Market	b	ue to (or es e conse					1
bunar-u	Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						
for use as the burlet-transit clan/Medical Examir	resulting in deeth) Last	Di d	ue to (or es e consec	quenca ot):				1
Clar						ant Bld		
be detached for usa by Physician/A	Part II. Other significant conditions	Contributing to deeth but	not resulting in the t	inderlying cause (oven in Pert I.		Yes 2000	ntribute to the cause of death' 3 Probably 4 Unknow
should							en eutopsy ormed?	24b. Were autopsy tindings evailable prior to completion of cause of death?
Paga 2						10	Yes 2240	1 Yes 2 No
lo Be C	25. Was case reterred to medical				26. Place of Dec	eth (Check only		
2	examiner? A	Hospitel: 1 Inpatient	2 ER/Outpetie	nt 3 DOA	Whor: \		dence 6 Oth	er (Specify)
lon:	27. Menner of Death 1 Natural 5 Pending 2 Accident investiget		Year) 28b. Time of Injury	W	ury et ork? Yes 2 No	28d. Describe	how injury occur	red
led in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not determine	28e. Plece of Injur- building, etc.	y - At home, term, st (Specify)	reet, fectory, office	8	28t. Location (City or To		per or Rural Route Number,
completely filled in by the Medical Certifical	29a. Certifier (Check only one) 2 Medical Ext	Physician: To the best of aminer: On the basis of e end menner stets	xaminetion end/or in	h occurred et the vestigetion, in my	time, date and place opinion, deeth occu	e, end due to the urred at the time,	cause(s) and ma date and place,	anner as stated. end due to the cause(s)
completely filled in by the	29b. Signature and title of certifier	1111111	1 . 1	29c. Lice	nse number			d (Month, Day, Year)
3	30. Neme and address of parson wh	LULUM completed cause of dea	AMA (Item 23a) (Type	Print)	25009	/	Juan	Mor 20 1990
	Dec. 1101110 and address of parson wit	a combinator perize of 066	m (monte set) (1 hbe					

State Registrar

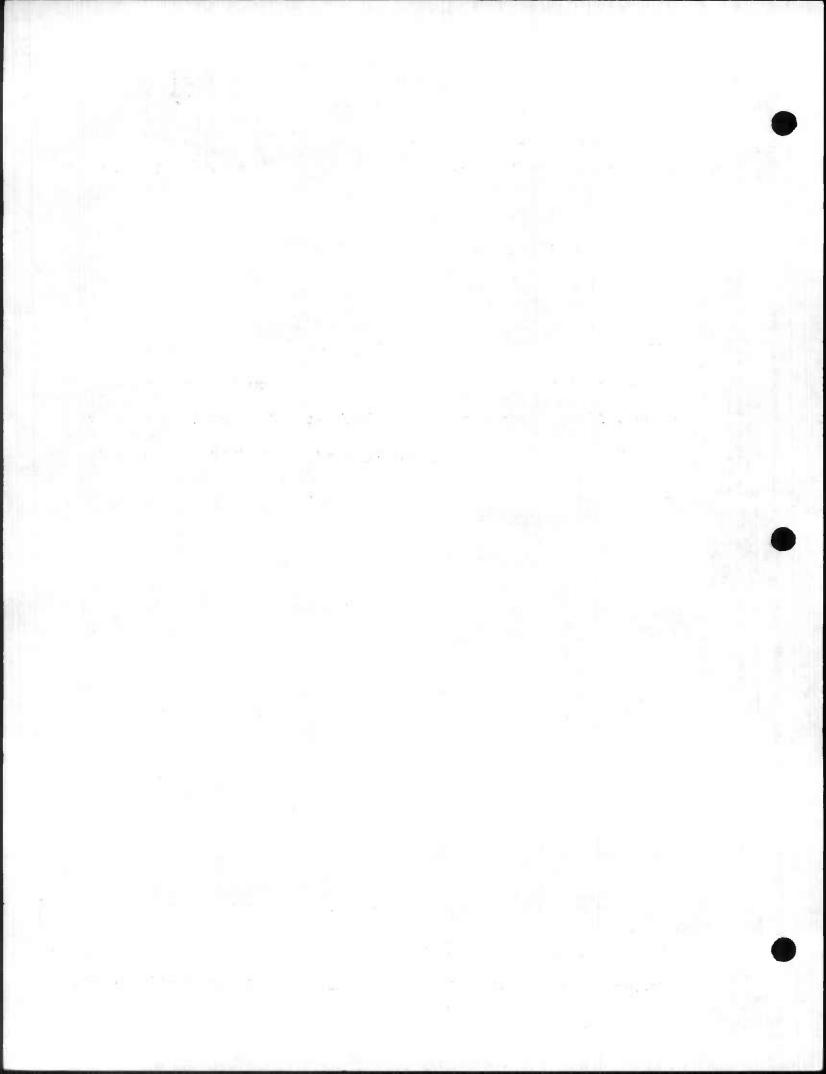
31. Dete tiled (Month, Dey, Year)

DEC 2 1 1999

DHMH 16 Rev 6/95

Pamela Mulshine, M.D. 11251 Lockwood Dr., Silver Spring, MD 20903
ete tiled (Month, Dey, Year)

32. Registrer's Signeture



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 0730 FREDERICK CALVIN DOUGLAS, SR Dec. 19, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Tackoma Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 10 M 2□ F Months Min Yrs 83 Director 223-16-3924 May 19, 1916 Virginia **Usual Residence of Decedent** 10e State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours effer deeth with the Marylen Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show shy injury or other traumatic event, the Medical Examinar must be notined at each each. 10h Counts 1 ☐ Yes 2 ☑ No Director Charles Waldorf 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2901 Hunt Ct. 20603 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Bleck, White, etc. 1 Yes 2 X No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black. à 3 ☐ Widowed 4 🖾 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Designer Florist 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) James B. Douglas Bessie Thomas Douglas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Son) Frederick Calvin Douglas, JR 2901 Hunt Ct Waldorf, Maryland 20603 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Prosperity Cemetery 12/27/99 Chantilly, Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ames Funeral Home, Inc.
8914 Quarry Road, Manassas, Virginia 20110
23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
Approximete Approximete Intervet Between Onset and Death **Physician** PULMONARY /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner DIASTOLIC attending physicien end for use as the buriel-transit cartificate be assented Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. CORONARY ARTERY Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown END STAGE RENAL DISEASE. CUA p 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? leted EXACERBATEN CONGESTIVE HEART PERIPHERAL FAILURE. 1 ☐ Yes 2 No MASCULAR DISEASE 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 100 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 27. Manner of Death 28b. Time of To the Hospital or Attanding Pl within 24 hours after deeth. To the Funeral Director: After t combletely filled in by the funera 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred : After 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City of Town, State) 4 Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contillier, 12-20-1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VILLAGE PARK DRIVE, GREENBELT MD Yussur MD 0-

DHMH 16 Rev 6/95

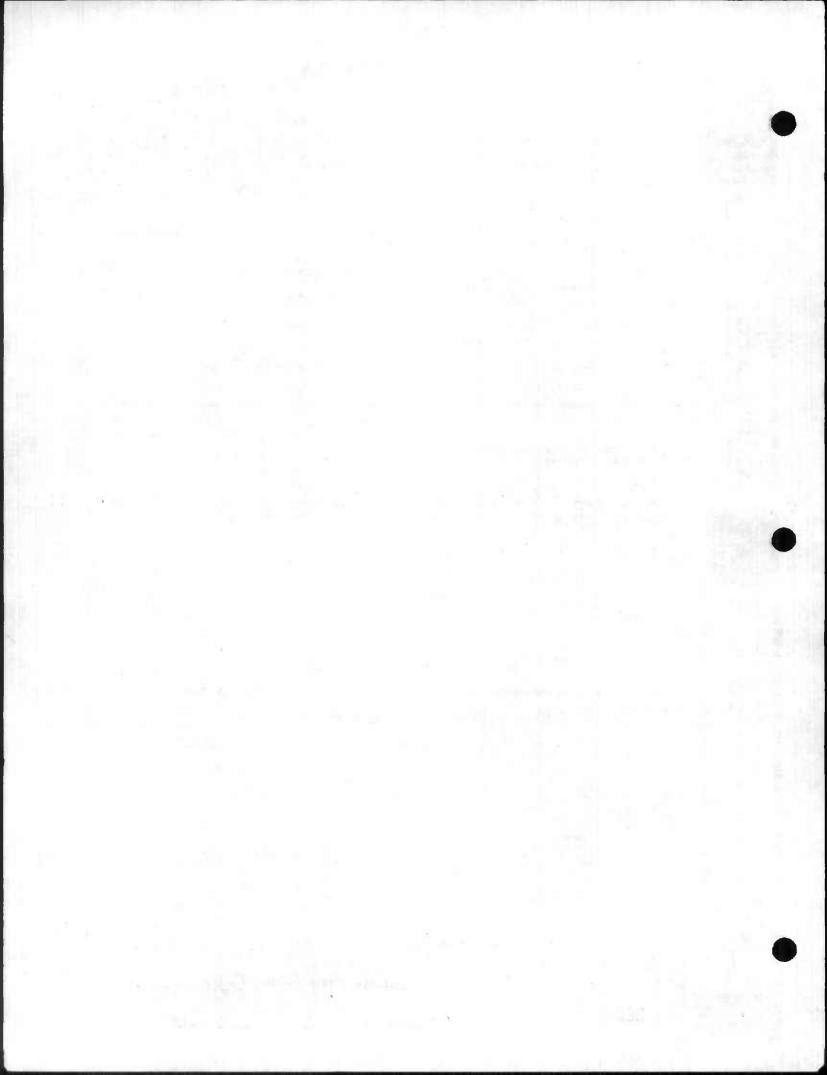
State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 1 1999

22 Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3 Time of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death DROZNIN -RIEDA 2 20 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not Institution, give street end number) MONTGOMERY ROCKVILLE HEBREW HOME OF GREATER WASHINGTON If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Under 1 Year Birthpiece (State or Foreign Country) RUSSIA 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Deys 1□ M 25 F 103/rs. 04.10.1896 167.26.7946 Usuei Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 XYas 2 No ROCKVILLE MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA 20852 6121 MONTROSE ROAD Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritei Stetus 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No WHITE 3 ☑ Widowed 4 ☐ Divorced 15. Decadent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) NECHA "UNKNOWN" SHLOMO WARSHAL 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 10300 LESLIE STREET, SILVER SPRING, MD 20902 SELMA FALLOON/DAUGHTER 20b. Pleca of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 12.22.99 ROCKVILLE, MARYLAND MENORAH GARDENS 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, only one cause on each line. Approximete Intervat Between Onset end Deeth Immediate Cause (Finat disease or condition resulting in death) PNEWMON ITIS FAILURE CONGESTIVE HEART Due to (or es e consequença of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use contribute to the cause of death? 1 | Yea 24 No 3 | Probably 4 | Unknown CEREBRAL 1SCHEMIA 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy performed? CORONARY ARTERY DISEASE 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

ettending physician and for use es the buriel-transit

signed by the

peen

s certificate hes b director, pege 2 s

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di

The law requires that the death certificate be executed

Box 68760

Division of Vital Records,

or Attending Physician:

To the Hospital

Physician/Medical Examiner

p

Completed

Be

10

Certification:

edicai

Physician

/Medical

Examiner

10e. Stete

Director

Funeral

p

Completed

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Med cal Examiner must be notified at

with the Meryland

death v

Peges 1 and 2 should be filed within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, tra Mandice.

Baltimore, Maryland 21215-0020

Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

28d. Describe how injury occurred

25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitei: Other: 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Menner of Deeth 28b. Time of 5 Pending Investigation 1. Naturel

28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work?

28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifie (Check only one)

2 Accident

3 ☐ Suicide

4 Homicide

Descritifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated.

29b. Signature end title of certifier enen 27330

29d. Date signed (Month, Dey, Year)

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

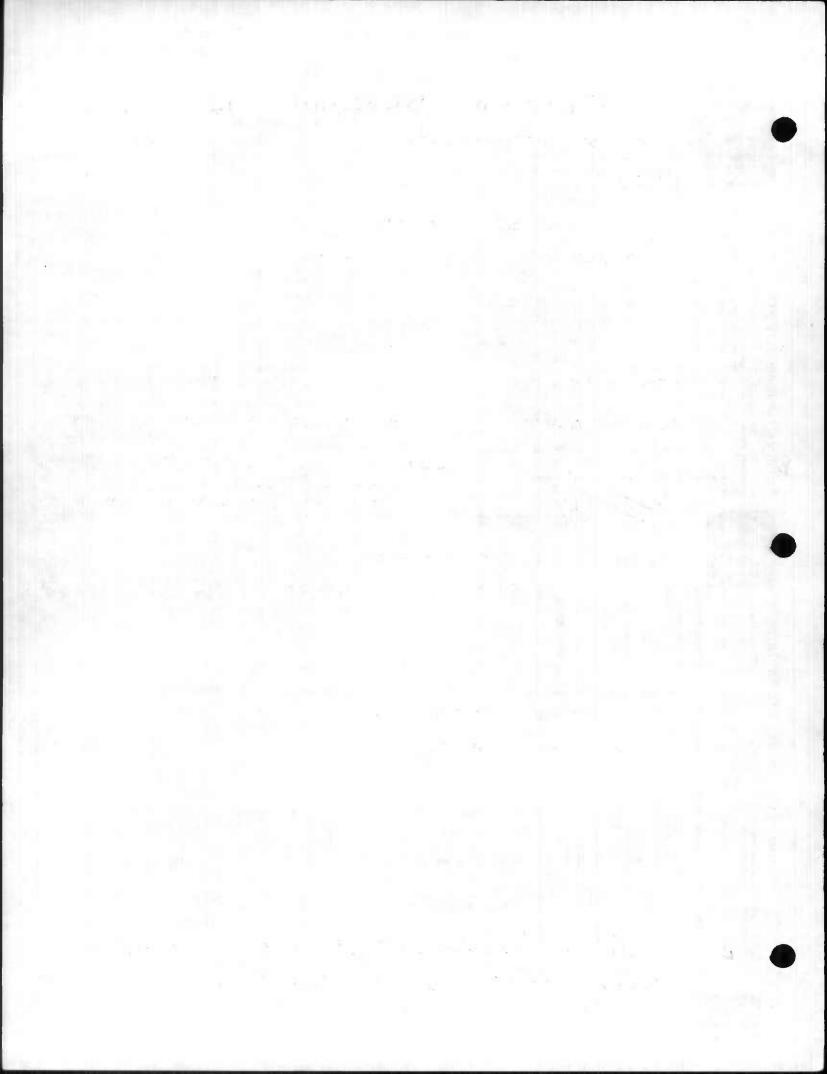
MONTROSE ROAD, LOCKVILLE, 4D PSON 612 31. Dete filed (Month, Dey, Year)

State Registra

DEC 23

6 Could not be determined

32. Registrer's Signeture



partment of	Health and Mental Hygiene	99
. 1 41	4.5	

Physiciar /Medica	n il -	1. Decedent's Nam		Ade	laide	M. 1	Dyer		Ab Ciby To	ouen or L	2. Data of D Month Decemb	per 18	19	99 9:	Tima of Death 20 P.M.
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Funeral Director		5. Social Sacurity N 579-62-5		6. Sax 1 □ M 2 X F		n yrs. last birt	hday) If Un Month	dar 1 Yaar Is Days							(State or Foreign
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to be	o Re Co	12 17. Father's Nama Jame		ast) raher			Seci	etary	18. Moth		a (First, Middle O'Ne	le, Maiden Su			iistrati
		19e. Informant's No.		Daughte	r		Mailing Addr				hesda,		0816		de)
0		20a. Mathod of Dis	position			20b. Place of	Diagonition /	lama of			Data	200 1 000	tion - Cit	ity or Town,	Stata
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State Registrar

31. Data filed (Month, Day, Year)

29b. Signetura end title of contine

DEC 21

Robert F. Dyer, M. D.

32. Registrar's Signature

30. Neme and address of person who completed cause of death (Itam 23a) (Type, Print)

Robert F. Dyer, M. D. 5530 Wisconsin Avenue Chevy Chase, MD

29c. Licensa number

D 04686

29d. Data signad (Month, Day, Year)

December 20, 1999

20815-4406

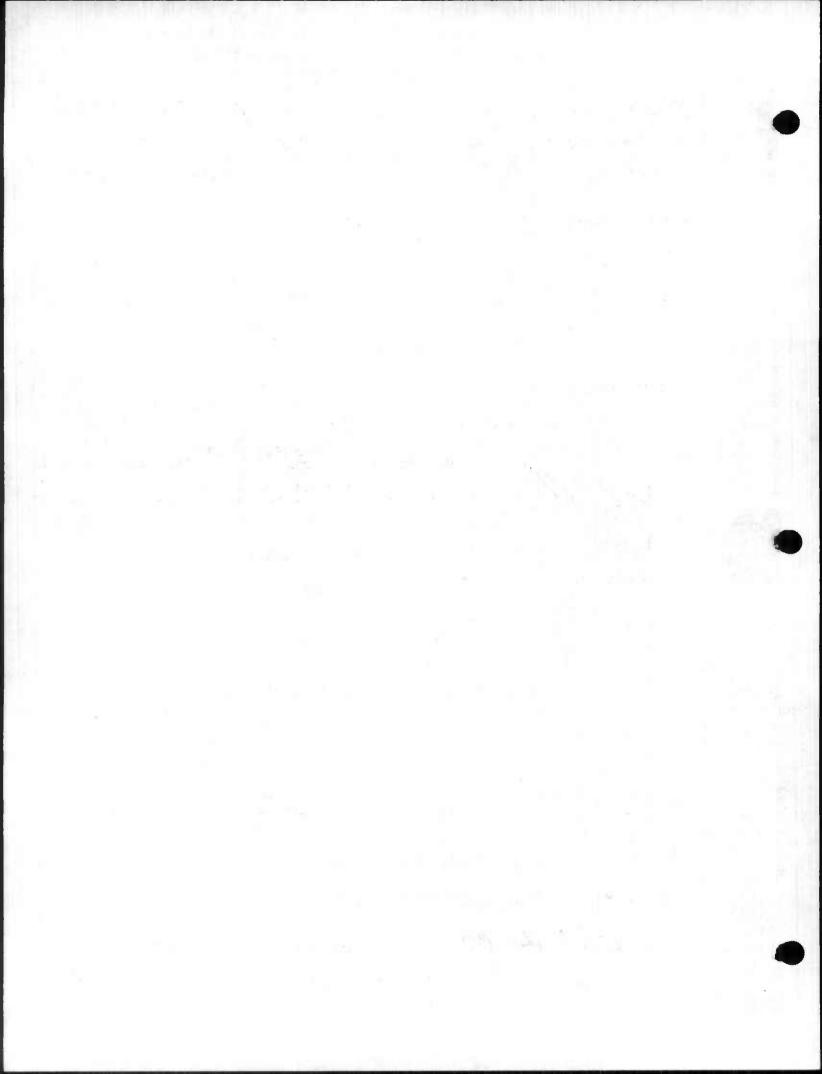
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State of Maryland / Department of Health and Mental Hygiene 99 1, 1792

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20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c.		
1 Buriel 2 Acremetion 3 Removel from State 1 Donetton 5 Other (Specify) Metro Funeral Services 23 Name and Address of Exciting		wn. Stete
M00668 4270 Hawthorne Rd., Indian Hi 23a. Pert1. Enter the isseese, or complications their caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or he in tailure. List only one cause on each line. Physician /Medical Examiner Immediate Cause (Fine) disease or condition resulting in deeth) Due to (or as a consequence of):	ead, Md. 2	20640 Approximete Interval Between Onset end Deeth
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Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobac 1 Yes	22 No 3□ Prob	bably 4 Unknow
24a. Wes en eu performed	1? eve	ere autopsy findings ellable prior to mpletion of cause deeth?
1 Yes 1 Ye	2 2 No 1	Yes 2□ No
25. Wes case referred to medical exeminer?		
25. Wes case referred to medical exeminer? 1 Yes 2 No	6 □Other (Specify	
25. Wes case referred to medical exeminer? 1		0
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29c. License number 29d. If the control of the time, determined the tim	e(s) end menner es ste and plece, and due to	eted. the cause(s)
	Dete signed (Month, D	
	12/28/90	1
30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) DR. LEATHER WOOD /2070 DLD LINE CONTRE, SHITE 2D2 WALDORF.	•	
State Registrar 31. Dete filed (Month, Day, Year) DEC 2 8 1999 32. Registrer's Signeture \$\mathcal{G}\$. Apartal		



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ate of Maryland / Department of Health and Men	ital Hygiene	99	1.1	78	3
Certificate of Death	Reg. No.			10	V

			Certificate of	Death	Reg	3. No.		100
	1. Decedent's Neme (First, Middle, L.	est)			2. Date of Death	Day 1	Year 3.	Time of Death
Physician /Medical		Davis			Month Decembe	r 20, 1		0:00 AM
Examiner	4a Cacility Blanca (Mant Institution of	ve street and number)		4b. City, Town, or Lo	cation of Death	4c. County of	f Death	
	1107 Notley Road			Silver S			gomery	
Funeral Director		Sex 7. Age (In yrs. lat	st birthday) If Under 1 Yee Months Deys	Hours Min.	8. Date of Birth (Month, Day,) Jan. 23,	1948	9. Birthplace Country) New Je	(State or Foreign
P 8 W	10a. State 10b. County	10c. City,	Town or Location				10d. le	side City Limits
desth with the Maryland rins 23s or 28s-f show Linsel be notified at	Maryland Montgo	mery	Sil:	ver Spring			1	☐Yes 次☐No
or 28a-f a be notified	10e. Street and Number		10f. Zip Code		100	g. Citizen of Wh	nat Country?	
in will be wil				20904	U	nited S	tates	
3 28 2	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Detes:	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Spe ban, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)		- American In , White, etc. Whit	
A should be filed within 72 hours at the and Mental Hygiene. It is marked other than "natural", or traumatic event, the Medical Exam. To Re Completed by F.	15. Decedent's E (Specify only highest gr		16a. Decedent's Usual Occu	upation	16	6b. Kind of Busi	iness/Industry	
ed within 72 ho ygiene. ver than "naturi 4, the Medical.	Elementery/Secondery (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retir	ed)	9	0.16	1	,
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id be fi		Davis	III	Audreay	(First, Middle, Ma	uoen Surrame)	Rowe	
2 should and Men is marks reummelic	19e. Informent's Neme/Reletionship		19b. Melling Address (Street					9)
	Robert Allan Bar		1107 Notley			0,	20904	Name .
ermit. Pages 1 ar Jepartment of Hea mportant: if Nem my Injury or othe NSE.	20a. Method of Disposition 1 Burlel 2 Cremetion 3 [4 Donetion 5 Other (Special Control of Control	THAURARI HOUR STATE	ca of Disposition (Name of netery, crematory or other ples apeake Crema	tory Inc	ec. 21 1999		ville,	
Depart Depart Import any inj	21. Signature of Funeral Service Lice	Kmann	Stephen D	ress of Fecility ral and Cr . Lohrmann Ave., Silv	P.A. er Sprin	g MD	20910	
Physician /Medical Examiner	23a. Pert1. Enter the diseese, or conshock, or heer feilure. List only Immediate Cause (Finel diseese or condition resulting in deeth)	e. RESPIRATORY Due to (or a		mig, such es cardiac o	riespiratory erres		Inter	roximete val Between et and Death
per insit		b. COMA						
certificate be executed ding physician and use as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events	c CEREBRAL EDE	MA s e consequence of):					
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ed by the detacher					1□ Yes	2⊠ No 3	3 Probably	4 Unknown
the se th								
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The law ale has b page 2 s					1□ Voc	2 (X) No	1 □ Yes	**
certificate rector, pag				26. Place of Deeth			7101	223140
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Attending Physic of death. ector: After this by the funeral diffication: To		28a. Dete of Injury (Month, Day Year)	8b. Time of 28c. Inj		28d. Describe how			
· kgsc T	3 ☐ Suicide 6 ☐ Could not to determined	28e. Pleca of Injury - At hom building, etc. (Specify)	e, ferm, street, fectory, office	2	28f. Location (Stre City or Town,	et and Number State)	r or Rural Rou	rte Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert		nysician: To the best of my knowle miner: On the basis of examinetion and menner steted.						
within To the comp	29b. Signeture end little of certifier	20	29c. Licer	nse number	290	d. Date signed	(Month, Day,	Year)
3	Bu ACA	ell,	D003	53242	De	ecember	20, 19	999
(20)	30. Neme and address of person who			Bethesda. N	Marvland	20892		
State Registrar	31. Dele filed (Month, Day, Year) DEC 2 1 199	32. Registrer's Signetur			jand	20072		
	DEO W 7 133	/	All Andrea All	-				

DHMH 16 Rav 6/95

Marie de Mille

DEC 2 7 1989

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State of Maryland / Department of Health and Mental Hygiene 99

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ical		NIE DAVI								2. Date of DECEME		1, 19	y 99 9	3. Time of Death 10:00an
iner	4e Facility Nem	e (If not institution,	give street and nu	umber)			4	b. City, To	own, or Lo	ocation of De	nth 4c.	County o	of Death	
	WASHING	GTON ADVE	ENTIST HO	SPITAL			T	AKOMA	A PAF	RK	MO	ONTGO	OMERY	
ı	5. Social Securit	y Number	6. Sex	7. Age (/n y	rs. last birthday)	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of E (Month, I	Birth (Day Year)		9. Birthple	ace (State or Fore
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cto	Md.	Montgo	mery	S	ilver S	pring	5							XXYes 2□I
Director	10e. Street and	Number				10f. Zip	p Code				10g. Citi	zen of Wh	hat Count	ny?
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Funeral	11. Marital Stetu	IS	12. Wes Dec	cedent Ever in	n U,S. 13.	Was Dece	dent of H	ispanic Or	igin? (Sp	ecify Yes or f Rican, etc.)	10-	14. Race Black	- America	
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State of Maryland / Department of Health and Mental Hygiene 99 41785

		Certificate of Death Reg. No.									100		
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	Examiner	4e Facility Neme (If not institution 3032 Qu	4b. City, Town, or Le Mount Ran							e's			
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Y						24 Hrs. 8. Date of	Birth Day, Year)			State or Foreign	
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	or 28a-f et be notified Director	VA	Alexar	Alexandria				XX					
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To the Hospital or													
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1		Styry A Vacto Mp O.C.M.E. December								19,	1999		
10	7)	30. Name and address of person					CI.	b D. 711				201	
-		Stephen S. 31. Date filed (Month, Day, Year	Radent	7	11.	r Penn	stree	t, Baltim	ore, M	arylan	212	201	
	State Registrar	DFC 2 3 19		istrer's Signeture	1								

950 2 2 3999 January 18. January

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** INA J. DAVIS DECEMBER 17, 1999 11:30pm /Medical 4a. Fecility Name (If not institution, give street and number, SPRINGBROOK NURSING HOME 4b. City, Town, or Location of Death 4c. County of Death
MONTGOMERY COUNTY **Examiner** SILVER SPRING 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country)
 JAMAICA 7. Age (In yrs. last birthday) **Funeral** Months 577-80-7065 1 M 2 XF 79 Days Hours Director FEB. 6, 1920 Usual Residence of Decedent the Maryland 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director WASHINGTON, D.C. 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with 928 HAMILTON ST N.W. 20011 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 □ Yes 2 □ No Specify: 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. pernit. Pages 1 and 2 should be filed within 72 hours efter Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural, or ite any injury or other traumatic event, the Medical Examination 1 Never Married 2 Married I ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0020 Specify: BLACK 2 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE PRIVATE INDUSTRY 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) MARGARET McMURRIN GERALD MARTIN 2 19a. Informant's Name/Relationship (Type, Pnnt) NORMA DOSWELL/DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8211 17th AVE. HYATTSVILLE, MD. 20a. Method of Disposition 20b. Place of Disposition (Neme of 20c. Location - City or Town, State 12/29/9 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stete
4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY BRENTWOOD, MD. 21. Signature of Fungral Service Licensee 22. Name end Address of Facility JOHNSON & JENKINS FUNERAL HOME 716 KENNEDY ST NW WDC 20011 Finter the diament, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, or heart failure. List only one cause on each line. Approximate interval Between Onset end Death **Physician** /Medical fmmediate Cause (Final Week disease or condition resulting in death) Examiner Diabetes mellitus Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed shysician and the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last P.O. Box 68760, Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown eumatoid arthritis Records, Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? director, page 2 should 24a. Was en autopsy performed? Hypertension 2 No 1 Yes 2 No Division of Vital 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA filled in by the funeral 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred After 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completely filled in by the fun 2 Accident 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homloide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated. Medical 29a, Certifier 29b. Signeture and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number December 21,1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Armstrong 14201 Loure PK Pr \$102 Laurel MD 20707 20 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **DEC 2 2 1999** Registra

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Secretary of the second

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 4 1 7 Certificate of Death 1. Dacedant's Nama (First, Middia, Last) 2. Data of Daath 3. Tima of Death Month Yaar Michael A. DuBose 12- 18-99 5:30 p.m. 4a. Facility Nema (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Numbar If Undar 1 Yaar If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth Birthplace (Stata or Foraign Country) Days Min 15XM 2□ F Yrs 45 05-03-54 D. C. 579-74-2363 Usual Rasidance of Decedani 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits D. C. Washington ₩ Yas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20011 5361 Chillum Pl., N.E. U. S. A. 12. Was Decedant Evar in U,S. Armed Forcas? 14. Raca - Amarican Indian, Black, Whita, atc. Was Dacadant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 Navar Marriad 2 Married 1 ☐ Yes 2 ☐XNo If Yas, Giva Yaar or Datas: 1 ☐ Yas 2 ☐ No Specify: Specify: Black. 3 ☐ Widowed 4 ☐ Divorced 15. Decedant's Education (Specify only highast grada complated) 16a. Dacadant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) U.S. Park Services Maintenance 3.5 yrs 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Edwin DuBose Olene Simon Jefferys 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code) 5361 Chillum Pl., N.E. Washington, D.C. 20011 Diane D. Jones (Sister) 20b. Placa of Disposition (Nama of camatary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 □ Burial 2 X Cramation 3 □ Ramoval from Stata Northern Virginia Crematory 12/23/99 Arlington, Virginia 4 □ Donation 5 □ Othar (Spacify) 21. Signature of Funeral Service Licenses 22. Nama end Addrass of Facility
W. H. BACON FUNERAL HOME, INC. Wonds C. Bacon cc036/ 3447 14th St., N.W. Washing 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Washington, D.C. Approximata Intarval Batween Onsat end Death Immediata Causa (Final disaasa or condition rasulting in daath) Sequantially list conditions, if any, laading to Immadlata causa. Entar Underlying Causa (Disaasa or injury that Initiated avants rasulting in death) Last Dua to (or es e consequança of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. DId tobecco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Onknown 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical 26. Placa of Daath (Check only ona) axaminar? Othar: 4□ Nursing Homa 5□ Rasidance 6 □Othar (Specify) 1 Yas 1 Impatient 2 ER/Outpatient 3 DOA 27. Mannas of Death 28d. Dascribe how injury occurred Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Natural 5 Panding invastigation

The lew requires that the death certificate be executed buriel-tran

Box 68760,

Division of Vital Records, P.O.

Physician

/Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

items 23s or 28s-f show

7 is marked other than "natural", or item traumatic event, the Medical Expression

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event.

Director

by Funeral

Completed

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with the Maryland

21215-0020

Baltimore, Maryland

Examiner Physician/Medical Completed by Be

certificate or Attending Physician: Certification: To filled in by the funeral After death. s efter death 24 hours Hospital Medicai

To the To the To the

State Registrar

2 Accidant

3 Sulcide

29a. Cartifiar

4 Homicide

(Check only one)

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify)

1 Yas 2 No

2 Medical Exeminar: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Dey, Year)

28f. Location (Straat and Number or Rurel Route Number, City or Town, Stata)

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

6 Could not be datarmined

AVE, TAKOMA PARK, MD 20912 7610 CARROLL MOBARAK ARIM, 31. Data filad (Month, Day, Yaar)

Cartifying Phyalcien: To the bast of my knowledge, death occurred at the time, data and piece, and due to the causa(s) and mannar as stated.

DEC 2 2 1999

29b. Signature end titla of certifier

32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				State	of Marylar			of Health and of Death	Mental Hy	giene 9	9	:1/88		
			Decedent's Neme (First, Middle, Last)							2. Dete of Deeth 3. Time of Death				
	Physician		MARY MARIE DAVIS							December 18 1999 6:				
	/Medi Examir		4a. Facility Neme (If not institution, g	iva straat and nu	mber)			4b. City, Town, or	Location of Deet	cation of Deeth 4c. County of Deeth				
4	Exami		9039 SLIGO CI	REFK PA	RKWAY	UNIT	408	SILVER	SPRING	MC	NTGO	MERY		
Г	Funeral			Sax	7. Age (In yrs.		If Undar 1 \	fear If Under 24 Hrs	s. 8. Dete of Bir	th		place (State or Foreign etry)		
	Director		294-12-3857	1□ M 2N F 86		S Yrs. Months Dey		eys Hours Mill	MAY 10	1913	1913			
	pd .	ctor	Usual Residence of Decedent 10a, Stete 10b, County		10- 01									
	8a-f show		MD MONT	MONTGOMERY SILVER SPRING							0d. Inside City Limits 1X□X/as 2□ No			
	\$ 9 E	Dire	10e. Street end Number				10f. Zip Code			10g. Citizen of				
	23a	To Be Completed by Funeral Director	9039 SLIGO C	REEK PA	ARKWAY	#408	#408 20901			Unite	ed St	States		
Baltimore, Maryland 21215-0020	filed within 72 hours efter deeth with the Maryland Hydiene ther than "natural", or items 23a or 28a-f show int, it a Medical Examinar must be notified at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	edent Ever in U,S. proes? 2 🕍 No ve pates: 13. Wes Decedent of H If Yas, specify Cuba 1 □ Yes 2 🖾 No				Hispenic Origin? (Specify Yes or No- can, Mexican, Puerto Rican, etc.) Specify:			14. Raca - American Indien, Bleck, Whita, atc. Specify: Black			
	n 72 ho "natura		15. Decedent's Education (Specify only highest grade completed)			16a. Deced	lent's Usuel C	occupetion lone during most of wo etired)	orking	ng 16b. Kind of Business/Industry				
212	withi ene. than		Elementary/Secondary (0-12) 11th	College (1-4or 5+)	Housewife				Dor	Domestic			
land 2	should be filed withind Mental Hygiene. I marked other than umatic event, the M		17. Fether's Neme (First, Middle, La	st)			110 45 6		me (First, Middle	e (First, Middle, Meiden Sumame)				
	id be ental ked c		Claude Henl			Ma	nie Evans							
ary	d 2 should but and Menta 7 ie marked trsumatic et	-	19e. Informent's Neme/Relationship	· · · · · · · · · · · · · · · · · · ·	T. T.	19b. Mailin	g Address (S	treet and Number or F	tural Route Numb	er, City or Town	, State, Zip	Code) 2090		
Σ	od 2 27 ie r tre		Sandra M. Gre	sham/Da	ughter									
re,	こまる		20e. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State											
E O	Peges nent of I int: If ite		1 Buriel 2 X Cremation 3 Removal from State 4 Donetton 5 Other (Specify) Term Cliff Cemetery 12-24-99 Springfield, Ol											
Balti	permit. Pege Depertment or Important: If i any injury or once.		21. Signeture of Funarel Service Licensee 22. Nama and Addrass of Facility Capitol Mortuary, Inc. 1425 Maryland Ave., NE Wash., DC 2000											
1			23a. Part1. Enter the disease, or co	mplications thet	caused the deel						,	Approximete		
	Physician /Medical	Physician/Medical Examiner	Immediate Cause (Final LUNG CANCER								Interval Between Onsat and Death			
	Examiner		disease or condition resulting in death)	ө.			mence of).			1				
					Due to (or as e consequenca of):									
Ć,	icete be executed physician end s the buriel-trensit		Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury	b	Due to (or es e consequence of):									
58760,	ysicia ysicia		thet initiated events	C	C Due to (or es e consequence of):									
-			resulting in deeth) Lest		(
Box	death certific e ettending pl ed for use es t		d								1			
Vital Records, P.O	deat		Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute								ontributa to	the cause of death		
	that the de ned by the	by Phy	1 Yes 2 No 3 Probably Unknow											
	law requires that as been signed b	Completed b								en eutopsy ormed?	av	ere autopsy findings eileble prior to mpletion of cause deeth?		
	0 5 5								10	Yes 20 No	1[Yes 2 No		
		0	25. Wes case referred to medical		26. Place of Death (Check only one)									
	yslo is ce dire	To 8	exeminer? 1 ☐ Yes 2 ☑ No	Hospitel: 1	lospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify)									
ion of	E je se		27. Menner of Deeth 1 Natural 5 Pending 2 Accident investigat			28b. Time of Injury		Injury et Work?	28d. Describe how injury occurred					
	or Attendil after death. Director: A d in by the fu	ertification:	3 Suicide 6 Could not determine	d 289. Piece	28e. Pleca of tnjury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Streat and Number or Rural Route Number, City or Town, State)				

ed by the ettending physical deteched for use es the ate has been significant page 2 should be To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

Physician/Medic Completed by Be Medical Certification: To

State Registrar

5 Pending investigation 6 Could not be determined 28e. Pleca of tnjury - At home, farm, street, factory, office building, etc. (Specify)

1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end placa, and dua to the ceuse(s) end menner stated.

29c. Licansa number D39456 29d. Date signed (Month, Dey, Year)

Dec. 20, 1999

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

5530 Wisconsin Ave. Ste.930 Chevy Chase, Md. Lila McConnell, M.D.

31. Dete filad (Month, Day, Yeer)

29b. Signature end title of certifier

29e. Certifier

(Check only one)

DEC 2 2 1999





1287 2 1 130

Piease Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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Sawara	DICCCI	DULGE	
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Funeral Director	405-		9x 7. Ag	ga (In yrs. last 41	Yrs.	Months D	Peys Hours	Min.					
ms 23a or 28a-fahow Emust be notified at neral Director	10a. Stete	ence of Decedent 10b. County		10c. City, To	own or Loc	ation	-77			Od. Inside City Limits			
28a-f ahow notified at rector	MD	Alle	egany		Cui	mberl	and					1 XYes 2 No	
r hems 23s or 28s-fa foer must be notified Funeral Director		and Number O Hinkle	Road			10f. Zip Co		1502		10g. Citizen of W	/hat Count	try?	
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by F		owed 4 Divorced	If Yes, Give Yaer or Detes:	1975-	79 1	☐ Yes 2☐	No Specif	y:		Specify:	whi	te	
		15. Decedent's E		11	6e. Decede	ent's Usuel C	Occupation	nat of working		16b. Kind of Bu	siness/Ind	ustry	
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7 la marke traumatic To	19a. lgform	ant's Name/Ralationship (Type, Print) 5) Durst	1	96 Mailing	Address (S	itreat and Num	ber or Rura	Route Numb	ac City or Jown,	State. Zio MD 2	1502	
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any i	1	re of Funeral Service Licer	1 hou	2000		Cumbe	rland	, Mar	yland	2150			
	23a. Pert1. shock	Enter the diseese, or cork, or haart feilura. List only	plications thet cause one causa on each I	d the death. L	o not ante	r the mode o	of dying, such a	as cardiac o	r respiratory a	rrest,	- 1-	Approximete intervel Between	
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al Director: After ted in by the funeral Certification:	3 ☐ Sui	cide 6 Could not b	e 286. Plece of in	njury - At home	farm, stre	et, factory, c	ffice	2	28f. Location	(Street and Numb	ar ar Rura	Route Number HINKLE	
Ceri ed in	45,110		building, a	FOUNI	TAC		DENCE			RLAND,			
Minin 24 hours after open To the Funeral Director: completaly filled in by the Medical Certifical	29a. Cartifie (Check		ysician: To the best niner: On the basis	of examination	dga, daath end/or inv	occurred et estigation, In	tha time, date my opinion, d	and place, a aath occurre	and due to tha	causa(s) and ma dete and place,	nnar as st and dua to	ated. the ceuse(s)	
Med	one)	ure and title of certifier	and thanner s	tated.		29c I	icense numbe	or .		29d. Date signe	d (Month.	Dev. Year)	
90 -	200. orginali	and the or oather	14/			200. 2	O.C.M.			Decembe:			

State Registrar

31. Data filed (Month, Day, Year)

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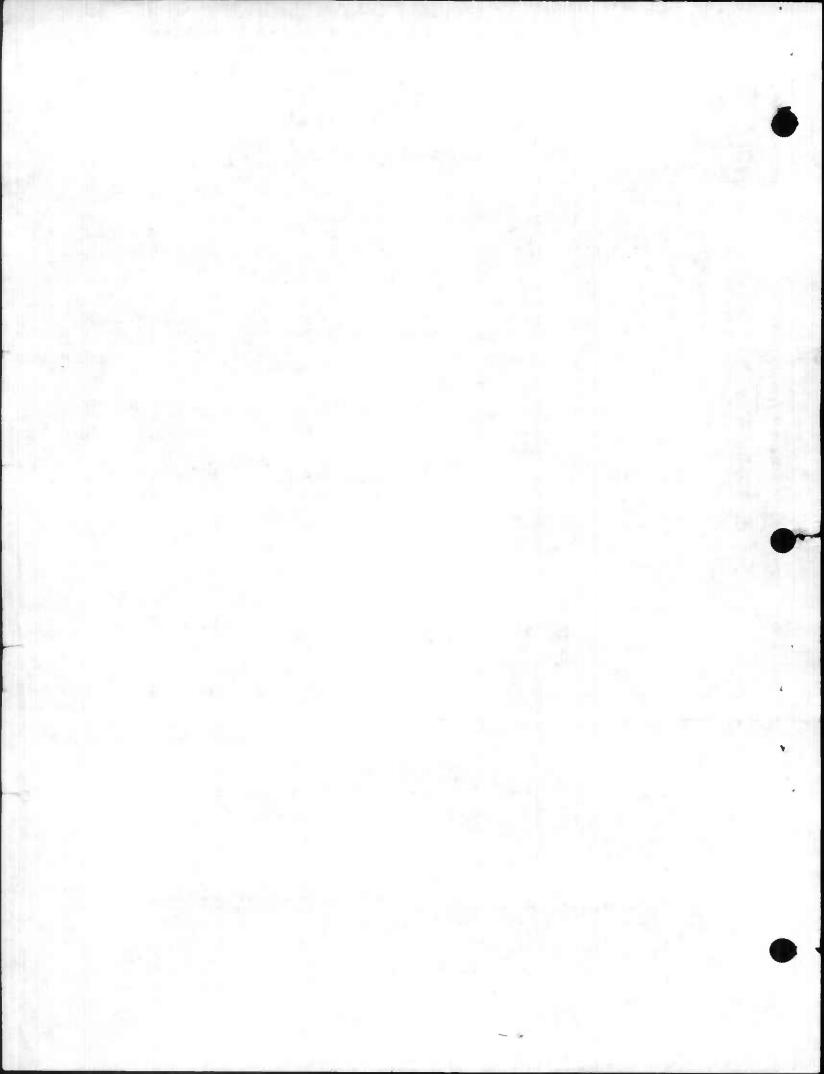
32, Registrar's Signatura

30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

DHMH 16 Rev 6/95

ORIGINAL

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Tima of Death **Physician** DECEMBER 21,1999 6:30 AM HAZEL GRACE **ETCHELLS** /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner SANDY SPRING FRIENDS NURSING HOME MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplaca (Stata or Foraign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2@F Yrs. 154 12 9545 84 Director AUG.23,1915 MASSACHUSETTS Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. MONTGOMERY SANDY SPRING 1 ☐ Yes 2 No Directo Nems 23s or 28s-f with the 10f Zin Code 10g Citizen of What Country? 10e Street and Number 17310 QUAKER LANE 20860 C/7 UNITED STATES Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after mant of Health and Mental Hygiens. Institute 27 is marked other than "natural", or the ury or other traumatic event, the Medical Examina 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: WHITE à 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HAND TABULATOR RADIO RESEARCH 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) 88 FREDERICK MAXAMILLION AURICH KATHERINE MADELINE KOENIG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) VALERIE A. GATES, GRAND-DAUGHTER 9501 FOXLAIR PLACE, GAITHERSBURG, MD. 20882 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important if any Injury or once. GEORGE WASHINGTON CEM. 12/22/99 ADELPHI, MD. 4 ☐ Donelion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MURIEL AND BARBER FUNERAL HOME N. Bark muriel P.O. BOX 5038, LAYTONSVILLE, MD. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Daath **Physician** /Medical Immediate Cause (Final Malignant disease or condition resulting in death) Lung Examiner Du to (or es a consequence d Examiner Obstructive Pulmonary Disease The law requires that the death certificate be executed physicien and the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical Due to (or as a consequence of) 987 e signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. Records, P.O. 15 Yes 2 No 3 Probably 4 Unknown ò 24b. Were autopsy findings available prior to should should 24a. Was an autopsy performed? Completed completion of cause of death? page 2 1 Yes 2 No 1 Yes 2 No of Vitai Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) edical Certification: To 1 Yes 2 No this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 1 Natural Division or Attending 5 Pending investigation sefer death.

Pirector: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 ☐ Homicide Hospital 24 hours the Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

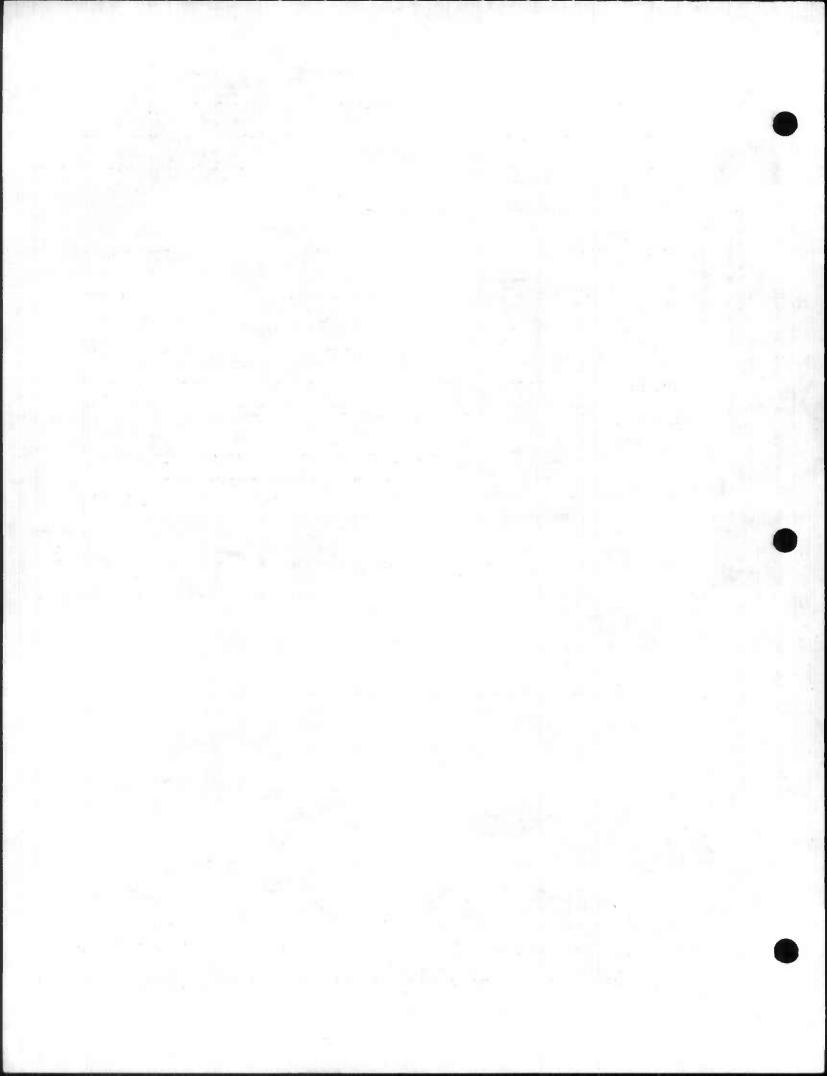
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi (Check only 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier evvett Morrison my 047682 DECEMBER 21,1999 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. BENNETT MORRISON, 2901 OLNEY-SANDY SPRING ROAD, OLNEY, MD. 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

DEC 23

1999



99-7656-033 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene HARVEY EMMIT Certificate of Death INNIS 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Harvey Emmitt Ennis 10:20 AM DECEMBER 20, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES PRINCE GEORGES HOSPITAL Cheverly
If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours Days X M 20 F Yrs. 215 01 0729 Director 87 July 17, 1912 Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location Show 10d. Inside City Limits 1 ☐ Yes 2 ➡ No Directo MD 28a-f P.G. Capitol Heights 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 234 5205 Doppler Street Funeral 20743 United States Hems : 12. Was Decedent Ever in U.S. Armed Forces?

120 Yes 2 No 1942
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 6 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced 1945 Year or Dates: natural XX White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Civil Engineer Inspector Federal Government Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be of Health and Mental George Ennis Margaret King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gretchen C. Ennis (WIFE) 5205 Doppler Street, Capitol Heights, Maryland 2074B 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec 28, 1999 20a. Method of Disposition 20c. Location - City or Town, State ō permit. Pages Department of Important: If It any injury or or MUBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery Cheltenham, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Europe Service Licenses Alexandria Ferry Road, Clinton, Md 20735 23a. Part 1. Enter the disease, or complimations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Candiovascular disease a. Atherosclerotic Examiner Due to (or as a consequence of): Examiner The law requires that the death certificets be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequenca of): Box 68760. physician Physician/Medicai Due to (or as a consequence of): USB. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed by 24b. Were autopsy tindings available prior to completion of cause of death? Limited has certificate Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 【XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation Attending Natural death. 1 Yes 2 No To the Hospital or Attendi within 24 hours after death To the Funerel Director: A 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide filled in 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

Registrar

Stephen 5.
31. Date filed (Month, Day, Year)

DEC 2 3 1999

29b. Signature and title of certifie

111 Penn Street, Baltimore, Maryland 21201 Radentz

30. Name and address of parson who completed cause of death (item 23a) (Type, Print)

32. Registrar's Signature

DHMH 16 Rev 6/95

29c. License number

OCME

29d. Date signed (Month, Day, Year)

DECEMBER 21, 1999

0001 & S 1340

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health		ıl Hygier Reg. i	99	41792
	Dhamis		1. Decedant's Nama (First, Middla, Last)		a of Death	Tay V	3. Tima of Death
Ц	Physici /Medi		Donald Albert Eckenroth	Dec	embei	20, I	999 7:15am
j	Examir		4a. Facility Nama (If not institution, giva streat and number) 4b. City	ty, Town, or Location of	of Death	4c. County of	Death
	Funeral Director		H111 Haven Nursing Home Sil 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Months Days How 207-07-1034	lver Spri	ng a of Birth nth, Day, Yei uary	Mont 9,27,19	gomery Birthplaca (Stata or Foraign 17 Pennsylv
-		1	Usual Rasidenca of Decedant				
- September 1	thow	_	10a. Stata 10b. County 10c. City, Town or Location				10d. Insida City Limits
th the Marvison	- Sill	Directo	Maryland Montgomery Silver Spring				1 Yas 2 No
9 400	23a or 2		10e. Street and Number 10f. Zip Coda 13804 Overton Lane 20904	4		Citizan of Wha nited	States
Maryiand 21215-0020	natural", or items 23e or 28e-f show dical Examinar must be notified at	by Funeral	11. Maritaf Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evar in U,S. Armed Forcas? 1 Nevar Married 13. Was Decedent of Hispani If Yas, specify Cuben, Ma 1 Yas, Give Yaar or Datas:	ic Origin? (Specify Ya xican, Puarto Rican, a ecify:	s or No- atc.)	Black,	Amarican Indian, Whita, atc. Thite
5 5	"naturel", edical Ex	bet	15. Decedant's Education 16a. Decedant's Usual Occupation		16b.	Kind of Busin	
7 1	, E 5	Completed	(Specify only highast grada completed) [Giva kind of work done during life. DO NOT use retired) [College (1-4or 5+)]				
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Mai	Tin or		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and N				
Dailimore, I	nt of Health I If Hem 27 or other to		E. Carolyn Eckenroth/Wife 13804 Overton 20a Method of Disposition XDBurial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Sectiv) National Memorial	1 2D/sta	2 2 20c.	Location - Cit	yor Town, Stata Church, VA
	モ론을 .		A CONTRACTOR OF THE PROPERTY O	1			
0	Depa Impo		21. Signature of Funeral Service Licensee 22. Nama and Addrasa of F				
			Port1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, succeed, or heart failure. List only one cause on each line.	ch as cardiac or raspir	atory arrast,		Approximata Intarval Batween
	nysician Medical xaminer	Ì	Immediate Cause (Final disease or condition resulting in death) AS PICUA'DA PARAMETER OF PROPERTY OF THE PROP				Onsat and Death IMMH
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5 8	2 2	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in i	Part f. 23	b. Did tobac	co use contri	buts to the cause of death?
- 5	det de	by Ph	Degenerative Soint Disease		1 🗆 Yas	2000 3	☐ Probably 4 ☐ Unknown
he law requires 1	been s should	Completed	Confestiva Heart Forture	24	a. Was an au performad		24b. Ware autopsy findings availabla prior to completion of causa of daath?
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9 9		iio	27. Manner of Death 28a. Data of Injury (Month, Dey Year) 28b. Tima of fnjury at Work? 28c. Injury at Work?		scribe how in	njury occurred	
Affending	er death actor:) by the	Certification:	2 Accident invastigation 3 Suicida 6 Could not be		nation /Otraci	and Mumbar	or Dural Pouts Alumbar
5 8		i i	datarmined 28a. Place of Injury - At home, ferm, street, factory, offica building, atc. (Specify)		y or Town, Si		or Rural Routa Number,
the Hospital	within 24 hours after To the Funeral Dir completely illed in	edical Co	29a. Cartifiar (Check only Madical Examiner: On the bast of my knowledge, deeth occurred at the time, de	eta and place, and dua	to the cause	(s) and mann	ar as stated. If due to the causa(s)
ž	the s	Med	one) and mannar stated.				
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1	10/		30. Nama arid addrass of person who complated causa of death (Itam 23e) (Type, Print) Pamela Mulshine 11251 Lockwood Dr. Silve	er Sprins	z. MD	20901	
1	Sta	ate.	31. Data filed (Month, Dey, Year) 32. Registrar's Signatura	er ohrrus	, III	20701	
	Reaisti		DEC 2 2 1999				

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State of Maryland / Department of Health and Mental Hygiene 99

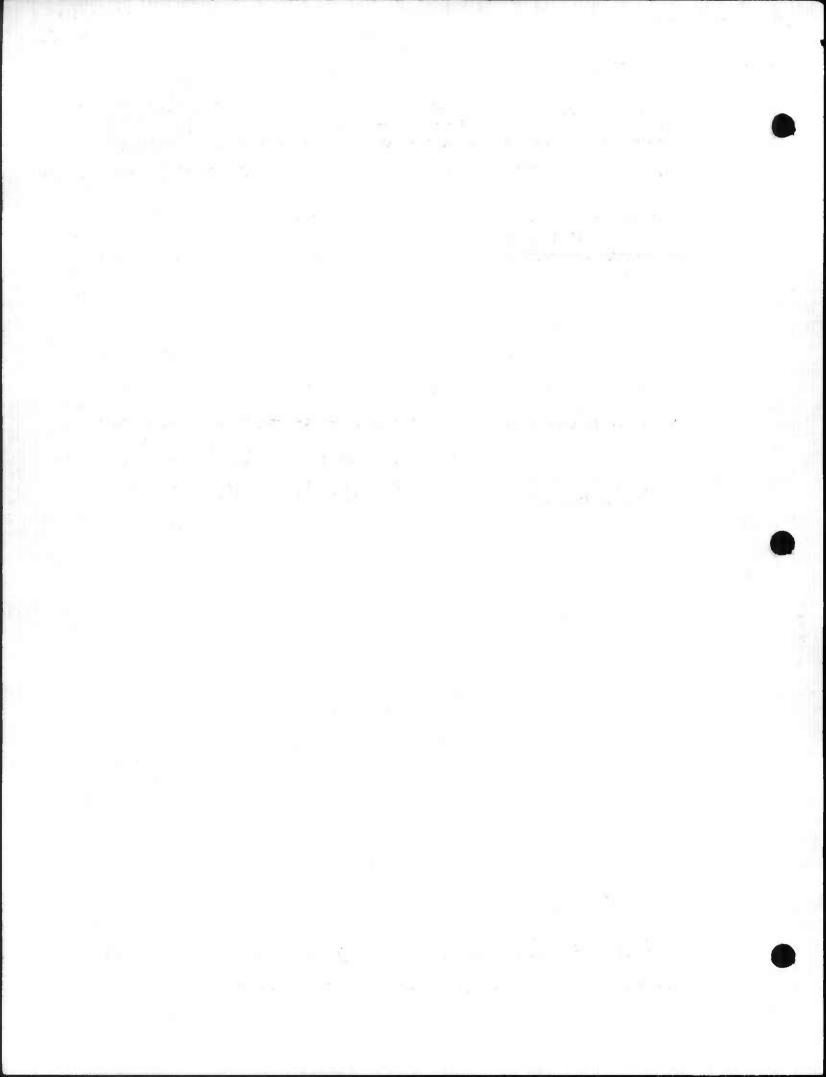
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men	d item 4a	,10	e per fh G779 1/13/00 yg Certificate of Death		Reg. No.		
			1. Decedant's Nama (First, Middla, Last)	2. Data of D	eath	No. 15	3. Tima of Death
	Physic /Medi		Leah B. Felton	Month 12	Day	Last	0445
	Exami			wn, or Location of Dea	th 4c. County	of Death	1.0
			Brooke Grove The Meadows Nursing Center Sand	y Spring	Mon	itgom	nery
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н	Director		157 01 1148 TEM 24XF 84 Yrs.	Min. (Month, D May 9,	1915	Penn	sylvania
	pur *		Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location				10d. inside City Limit
	/ show	5	Maryland Montgomery Sandy Sprin	œ			1 ☐ Yas 2 ☑ N
	the A	Director	106. Street and Number 17401 Norwood Road 10f. Zip Coda	8	10g. Citizen of V	Affron Cour	
	death with the Maryland ms 23a or 28a-f show must be notified at		1639 Hickory Knoll Rd. 20860				
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Maryland 21215-0020	or its	by Funeral	11. Marital Status 1 □ Navar Married 2 □ Married 1 □ Navar Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Evar in U,S. Armed Forces? 1 □ Yas 2 ☒ No If Yas, Siva Yaar or Datas:	, Puarto Rican, atc.)	Specify	k, Whita,	
5-0	"netural",	Completed	15. Decedant's Education (Specify only highast grada complated) [Giva kind of work dona during most life. DO NOT usa retired)	of working	16b. Kind of Bu	ısinass/ir	ndustry
21	i within 72 h jiene. r than "natu me Medical	nple	Elamantary/Secondary (0-12) Collega (1-4or 5+)	or working			
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and	S a b S	Be		r's Nama (First, Middle	a, Ma <i>id</i> an Su <i>man</i>		
Z Z	2 should and Mer is marks	10	Walter Rutter Burg Core			Stin	
Ma	d 2 should th and Mer 7 is marks trsumatic		19a. Informant's Name/Raletionship (Type, Print) 19b. Meiling Addrass (Straat and Numbe				
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Jo	ages nt of mt of		1 Burlat 2 X Cramation 3 Demoval from State cematary, cramatory or other place)	Dec 22			
Baltimore,	it. P.		4 Donation 5 Dothar (Specify) Chesapeake Crematory I: 21. Signatura of Funeral Service Licentities 22. Nama and Address of Facility		Belts		e, MD
Ва	permit. Pages Department of Important: If I any Injury or once.		Rapp Funeral and Stephen D. Lohr	mann P.A.	MD	es 2091	0
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	/Medical Examiner		Immediata Causa (Final disaasa or condition rasulting In death) a. TNAN MODEL			-	2 months
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Division of	Attending or death.	fica	3 Suicide 6 Could not be 28a. Place of Injury - At home, ferm, street, factory, office	28f. Location	(Street and Numb	er or Rur	ral Routa Number,
ă	after after Directory	Certification:	4 ☐ Homlolde building, etc. (Specify)	City or To	iwn, State)		
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edicai (29a. Certifiar (Check only one) Certifying Physicien: To the best of my knowladge, deeth occurred et the time, deta and 2 Medical Examiner: On the basis of axamination and/or investigetion, in my opinion, deat and manner stated	d place, and due to the h occurred et the time	ceusa(s) end ma , data and placa,	inner as a	stated. to tha causa(s)
	ithin ithe of the ymple	Med	one) and manner stated. 29b. Signatura and titla of certifiar 29c. Licensa number		29d. Data signe	d (Month	Day, Year)
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	10		30 Name and disease of source who constituted and the same of the	Y)	15151	179	
			30. Nama and address of person who completed cause of death (Itam 23a) (Type, Print) John E. C. 733 CLOVERLY ST. SILVER SPRING, MARKY		0905		
			133 CLOVERLY ST. SILVER SPRING, MARY	CHUD)	2402		

32. Registrar's Signatura

State

31. Data filed (Month, Day, Yaar) DEC 2 2



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 12/22/99, BMW, Montg. Co. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month Physician December 16, 1999 Lucille Ferrel1 3:10 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Montgomery Village Rehab Gaithersburg Montgomery Hours Min. 8. Date of Birth (Month, Day, Year) 04/19/11 9. Birthplace (Stete or Foreign Country) VA If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Funera Days Months 1□M 2₽F 89 228-92-0629 Spotsylvania, Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d Inside City Limits VA Spotsylvania Fredericksburg 1 ☐ Yes 2 X No Director 289-7 6 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? ä 9531 Elys Ford Road 22407 Berns 23a USA Funeral 12. Was Decedent Ever in U,S. Armed Forces?, 1 ☐ Yes 2 Dillo If Yes, Give Year or Dates; Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck White etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: "natural", or 21215-0020 Specify: 3 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home . Pages 1 and 2 should be filed wi timent of Health and Mental Hyglen tant: If Nem 27 is marked other th jury or other traumadic event, tha Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 96 Joseph C. Hawkins, Sr. Lena Fitzhugh 19a. Informant's Name/Relationship (Type, Print) Niece 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 17415 Applewood Lane; Derwood MD Eileen Eshleman - Daughte 20b. Place of Disposition (Name of cemetery, cremetory or other place) 12/19/99 20c. Location - City or Town, State Department of important: If It any Injury or o Spotsylvania, VA 4 Donation 5 Other (Specify) Wilderness Baptist Church Cemetery 22. Name and Address of Fecility 21. Signature of Funeral Service Licenses Metropolitan Funeral Service theren E.1 5517 Vine Street, Alexandria, VA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teiture. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical preumomo Examiner Due to (or as a consequence of): Examiner concertive heart failure
Due tolor as a consequence of): physician and the buriel-transit The law requires that the death certificate be asscuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760. Due to (or as a consequence of): one geas Physician/Medical resulting in de 897 P.O. signed by the aid be detached f 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yes 2 No Records. à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 8 No 1 Tyes 2 No Division of Vitai To the Hooptal or Attending Physician: within 24 hours effer death.

To the Funeral Director: Affer this certifical completely filled in by the funeral director, Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 DNatural 1 Tyes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3∏ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a. Certifie (Check only one) iner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 20 ceffell mo 033443 December 16,1999

State Registrar 999 32 Boolstrar's Signature

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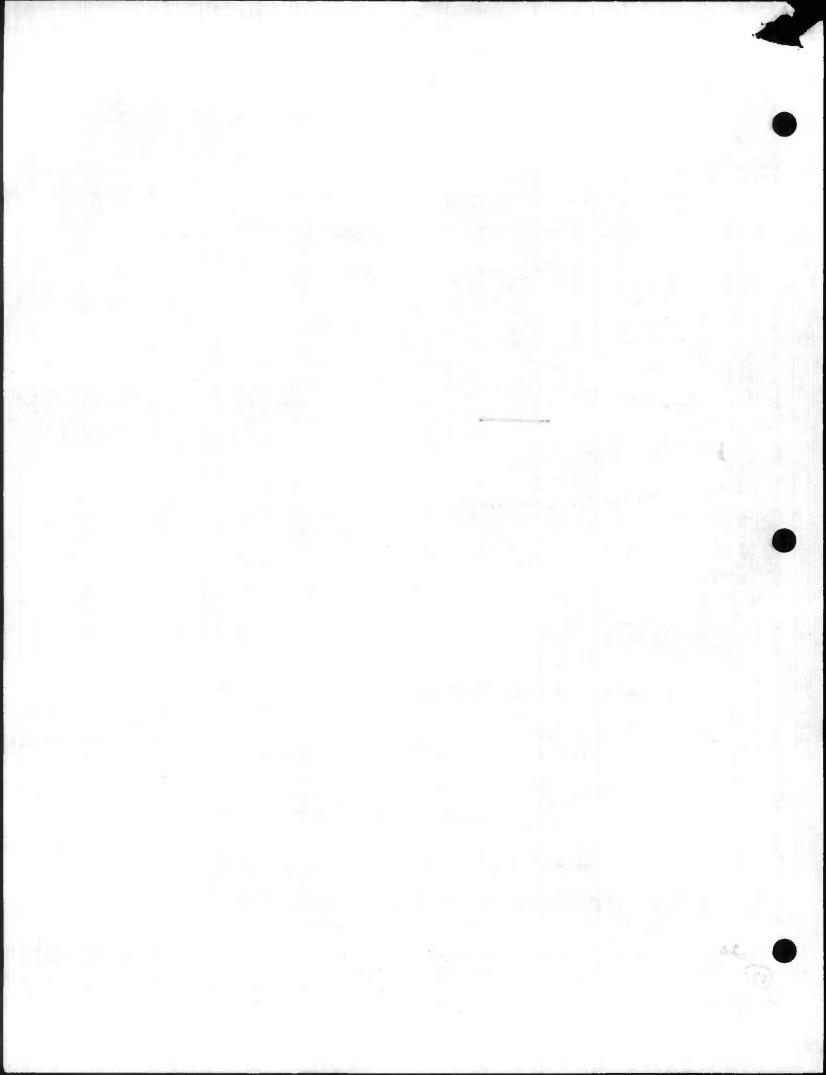
DEC 22 1999

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan R. Pellaela, m. O.

Sparks ma

(10)



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Day 14, 1999 DEC. 6:15PM BRUNO J. FIGALLO 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Deeth MONTGOMERY OLNEY MONTGOMERY GENERAL HOSPITAL 8. Date of Birth (Month, Dey, Year) SEPT. 22, If Under 24 Hrs. Hours Min. If Under 1 Year Birthplece (Stete or Foreign Country) ITALY 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex MM 2DF Months Deys Yrs. 1921 78 577-26-1419 Usuel Residence of Decedent 10d. Inside City Limits 10a. Stete 10b. County 10c. City, Town or Location 1 Yes 2 No MARYLAND SILVER SPRING MONTGOMERY 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number UNITED STATES 20906 13600 MILLS AVENUE 12. Was Decedent Ever in U,S. Armed Forces? 1XXes 2 □ No If Yes, Give Yeer or Dates: 1942-45 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 1 Never Merried Married 1 ☐ Yes 2XXNo Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done duning most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) College (1-4or 5+) Elementery/Secondery (0-12) FEDERAL GOVERNMENT COMMERCIAL ARTIST 18 Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) ROSETTA RIZZOLI CORNELIUS FIGALLO 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 13600 MILLS AVE. SILVER SPRING, MD 20906 URSULA FIGALLO/WIFE 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State 12/17/99 4 ☐ Donetion 5 ☐ Other (Specify) BRENTWOOD, MD LINCOLN CREMATORY 21. Signature of Funerel Service Licensee 22. Name end Address of Facility HINES-RINALDI FUNERAL HOME, INC. 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. MD 20904 11800 NEW HAMPSHIRE AVE SILVER SPRING, Approximete Interval Between Onset and Death Immediete Ceuse (Finel disease or condition resulting in death) Sequentielly list conditions, if any, leeding to Immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): Due to (or as a consequence of) 23b. Did tobacco use contributs to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes a No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings evalleble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 □ Yes 250 2 110 1 🗆 Yes 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 💆 No 1 Inpatient 2 □ ER/Outpetient 3 □ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Caturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 | Homicide

physician and s the burial-transit requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 88 use signed t certificata has b director, page 2 s or Attending Physician: director, After this funeral death. aftar deatl 24 hours aftar Funerel Dire letaly filled in b Hospital

Physician

/Medical

Examiner

Funeral

Director

show r 28a-f show

th and Mental hygiene. 7 is marked other than "naturel", or items 23a or traumatic event, the Medical Examiner must be a

permit. Pagas 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner mark once.

Physician

/Medical **Examiner**

Baltimore, Maryland 21215-0020

Directo

Funeral

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29e. Certifier

(Check only one) 29b. Signature an

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with

Physician/Medical

To the Hosp within 24 hor To the Fune completely fi 12

> State Registrar

Cartifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner es steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the cause(s) end menner stated. of certifier

29c. License number 356 ~D

29d. Date signed (Month, Dev. Year)

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30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print)

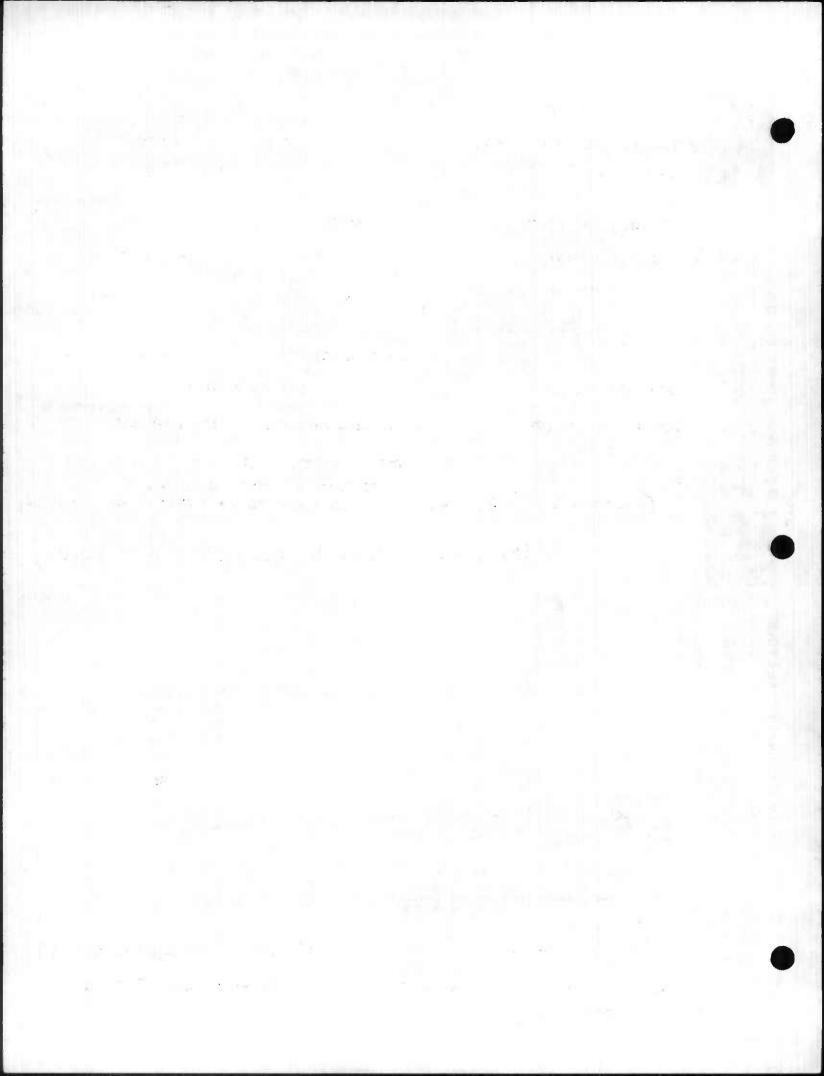
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orney, DI

Joseph KAPLA
31. Dete filed (Month, Day, Year) **DEC 20**

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32. Registrer's Signeture Jeneva



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	State of M	aryland / Dep <i>Ce</i>	artment of		ind M	, ,	iene C	19	41796
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JAMES	MAXINE FR	EDETTE				Month DEC	20 199	9 9 Yeer	11:04 PM
la. Facility Name (If not institution, g	iva street and number)			4b. City, Tov	vn, or Lo	cation of Deeth	4c. County		
NATIONAL NAVA	L MEDICAL	CENTER		BET	HESD	A	Mo	ONTGO	MERY
5. Social Security Number 181-22-4630	Sax 7. Ag	e (In yrs. iest birthday 70 Yrs.	Months Day		24 Hrs. Min.	8. Data of Birth (Month, Day, MAR 28	Year) 1929	Cou	placa (Stata or Foreign http:) NNECTICUT
Usuai Rasidanca of Decedant									
10a. Stata 10b. County		10c. City, Town or L							10d. Inside City Limits 1 XYas 2 No
	VARD	CAPE CA	NAVERAL						
10e. Street and Number 350 TAYLOR AV	'E		10f. Zip Cod	• 2920-04	31	1	og. Citizen of 'UN]		ntry? STATES
Meritel Status Navar Married 2 Merried Widowed 4 □ Divorced	12. Wes Decedant Armed Forces? 1 X Yas 2 ☐ If Yes, Give Yaer or Detes:		Wes Decadent of If Yas, specify C	uban, Mexican	in? (Spe , Puerto f	cify Yas or No- Rican, etc.)		ck, White,	can Indian, atc. WHITE
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JOSEPH FR	EDETTE				ESTH	ER BARBI	ER		
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LISELOTTE FREDET	TE /WIFE	P.	O.BOX 43	31 CAPE	CAN	AVERAL 1	FL 329	20-0	431
20a. Method of Disposition 1 Buriai 2 Cramation 3 4 Donation 5 Othar (Spec			osition (Nama of matory or other p		12	, ,	20c. Location		own, Stata
21. Signeture of Funarai Sarvice	mlois A	2	2. Name end Ad	drass of Facility	/				E, MD.2073
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						24a. Wes a	n autopsy ned?	av	ara autopsy findings aliable prior to impletion of cause death?
						1 □ Ye	s 2 No	10	☐ Yes 2☐ No
25. Was casa raferred to medical axaminar?			1		of Deeth	(Check only on	a)		
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Physician /Medical Examiner

The law requires that the death certificate be executed page 2 should be datached for use as the burlal-transit

has

cartificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartific. complataly filled in by tha funaral director, by

Completed

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Certification:

Medical

Division of Vital Records, P.O. Box 68760.

Physician

/Medical

Examiner

Director

Funeral

by

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Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Manyland Department of Hastilt and Mental Hygiens. Important: If Item 23 a or 28=f show any injury or other transmit and injury or other transmit

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if eny, leading to immadiata cause. Entar Undarfying Causa (Disease or injury that initiated avants rasulting in daath) Last **Physician/Medical**

25. Was casa raferred to medical axaminar? 1 Yas 2 No 27. Mannar of Death

1 Natural

2 Accident

3 Suicida

4 Homicida

28a. Date of Injury (Month, Day Year) 5 Panding investigation

28b. Tima of

28a. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify)

28c. Injury et Work? 1 ☐ Yas 2 ☐ No 28d. Dascribe how injury occurred

29a. Certifier

29c. Licansa number

29b. Signature and titia of cartifiar

MD

29d. Deta signed (Month, Day, Year)

6 Could not be determined

J-4743 (TX)

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

30. Nama and address of person who completed cause of daeth (Itam 23a) (Type, Print)

P.J.CHANDLER, CAPT, MC, USN

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

31. Data filed (Month, Dey, Year) **DEC 22** 32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Neme (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** TEHER OHN 3.30 am Dec 20 /Medical 4a. Facility Name (If not institution, giva straat and numbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner AIRHAVEN SYKESVILLE CARROLL If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Sept. 11, 9. Birthplace (State or Foreign 1906 Hungary 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys 1 XM 2□ F 93 Yrs. Director 212-01-8110 Usuai Rasidance of Decedant with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If the 127 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examines maint be notified as MD Carroll Sykesville 1 X Yas 2 □ No Director 10f. Zip Coda 10e. Street and Number 10g. Citizan of Whet Country? 7200 Third Avenue 21784 USA Funeral 12. Was Dacedant Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ∑ No If Yas, Give Yeer or Datas: Wes Decedant of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, etc.) Race - Americen Indian, Bleck, Whita, atc. 1 ☐ Navar Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: White þ 3 ☐ Widowad 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedant's Education (Spacify only highast grada completed) Elemantary/Sacondary (0-12) Collaga (1-4or 5+) 5 Insurance Broker Insurance 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maldan Surnama) John Feher Unknown 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mrs. Dorothy M. Fener (Wife) 7200 Third Avenue Sykesville, MD 21784 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Buriai 2 X Cremation 3 ☐ Removal from Stata All County Cremation Serv 12/20/99 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funaral Sarvice Licansea THATGHT AGUNERALLY HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the diseasa, or complication, that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immadiata Causa (Final disease or condition rasulting in death) Examiner Examiner Vasculan RII ed by the attending physician and detached for use as the burial-transit Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarfying Causa (Disease or injury that initiated avants resulting in daath) Lest Division of Vital Records, P.O. Box 68760, Physician/Medical Dua to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? signed by t 1 ☐ Yss 2 ☐ No 3 Probably 4 ☑ Unknown estive þ 24b. Wara autopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy 1 Yas 2 No 1 ☐ Yas 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was casa rafarred to medical 28. Placa of Death (Check only ona) Othar: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 25 No 2 1 Inpatiant 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: 5 Pending 1 Natural 1 Yes 2 No Investigation 2 Accident 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homleida 2 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the causa(s) and mannar stated. 29a. Cartifian Medical 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) Wright, MD 52740 30. Nama and addrass of person who complated causa of death (itam 23a) (Type, Print) KESUILLE, MI) Ernestine FAIRHAVEN Wright

DHMH 16 Rev 6/95

State

Registrar

31. Data filed (Month, Day, Year)

DEC 2

32. Ragistrar's Signetura

MELIZERS from D. Speed

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $9\,9\,$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month Day GAO ERWEN 0957 Dec 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death HOSPITAL If Under 1 Year ROCKVILLE
If Under 24 Hrs.
Hours Min.
8. Da SHADY GROVE ADVENTIST MONTGOMERY 8. Date of Birth (Month, Dey, Year)
May 30, 1952 Birthplace (State or Foreign Country)
 China 5. Scalel Security Number 7. Age (In yrs. last birthday) 1□ M 2√XF Months Days 578 21 0513 47 Usual Residence of Decedent 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18029 Driftwood Ct. 20877 Peoples Rep. of China 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Yeer or Detes: 14. Race - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married 1 Yes 2 No Specity: Chinese 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 12 Accountant Fishery 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Lan-Sheng Gao 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Yuan Yao / Husband 18029 Driftwood Ct., Gaithersburg, MD 20877 20b. Plece of Disposition (Name of cametery, cremetory or other plece) Date Dec.22 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1999 Beltsville, MD Chesapeake Crematory Inc 22. Name and Address of Facility.

Rapp Funeral and Cremation Services Stephen D. Lohrmann P.A.

933 Gist Ave., Silver Spring, MD

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. 20910 Approximate Interval Between Onset end Deeth Immediete Cause (Finel disease or condition resulting In death) anemia Due to (or es e consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of). Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24e. Was en autopsy performed? completion of cause of death? 20 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2ER/Outpetient 3□ DOA 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 1 Natural
2 Accident 1 Yes 2 No

Physician /Medical Examiner

certificate be axecuted

P.O.

Division of Vital Records,

permit. Pages 1 end 2 st Depertment of Heelth and Important: If Item 27 Is in any Injury or other traun once.

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

7 is marked other than "natural", or items 23s or 28a-f show traumatic event, the Modical Examinar must be notified at

2 should be filled within 72 hours aftar and Mental Hygiene.
Is marked other than "natural", or ite

altimore, Maryland 21215-0020

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death

Examiner the 88 950 should be

ician end bunal-transit attending physician signed by certificata has Hospital or Attending Physician:
24 hours after death.
 Funeral Director: After this certifice funeral

Physician/Medical p Completed Be 2 Certification:

To the Hosp within 24 hou To the Fune completaly fi

edical

25. Wes cese referred to medical examiner?
1 XYes 2 No

4 | Homicide

(Check only one)

29a. Certifier

5 Pending 3 Suicide

Investigation 6 Could not be determined

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) end manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end mapner stated.

29b. Signature end title of certified

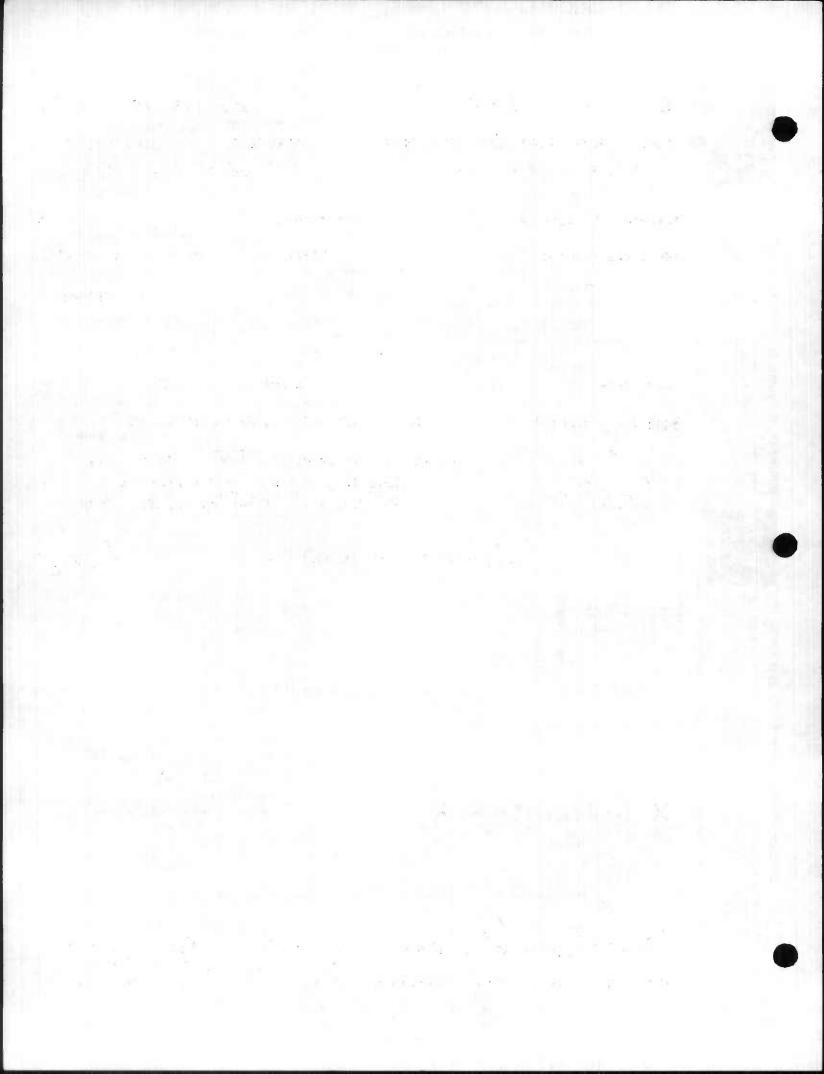
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29c. License number

29d. Dete signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print) HER moomE

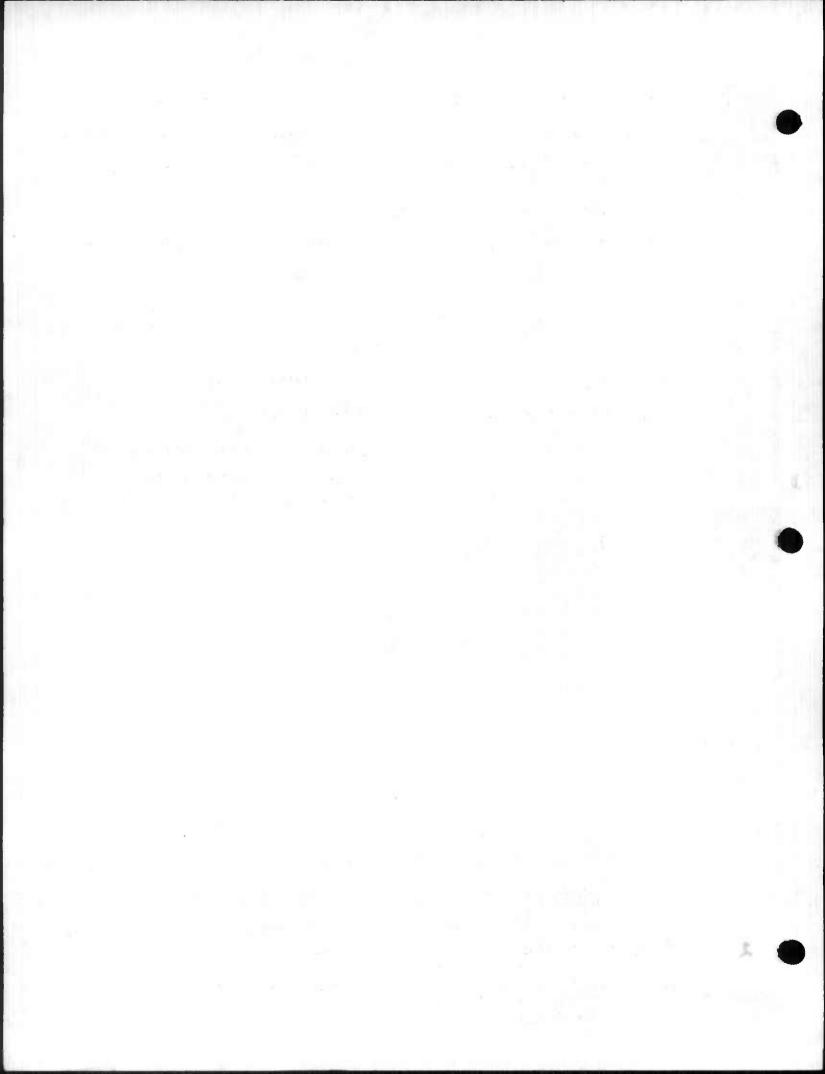
State Registrar 31. Date filed (Month, Dey, Year) **DEC 22** 32. Registrar's Signature



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		Decedent's Neme (First, Middle, Let			Certifica				Reg. No.	3. Time of Death
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Exami	ner	4e. Fecility Neme (If not institution, git 4314 LORI STREE					4b. City, Town, or Le SUITLAND	ocation of Deeth		of Deeth
Funeral Director		5. Social Security Number 6.		(In yrs. lest bir	thday) If Und Month	der 1 Yeer Deys		8. Date of Bir (Month, De Dec. 25		Birthplece (State or Foreign Country) N C
pue **		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location					10d. Inside City Limits
Manyl ef aho	tor		Georges		tland					X⊠ Yes 2 □ No
h with the	al Director	10e. Street end Number 4314 Lori Stree	et		10f.	Zip Code 207	46		10g. Citizen of I United	What Country? States
filed within 72 hours efter death with the Maryland hygiene. ther than "natural", or items 23a or 28a-f show ont, the Medical Examinat must be notined at	by Funeral	11. Maritel Status 1 ☐ Never Merried 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes Yes, Give Year or Detes:	ver in U,S.	If Yes, s	cedent of hoecify Cub	dispenic Origin? (Sp en, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ce - Americen Indien, ck, White, etc. g: Black
s filed within 72 ho Il Hygiene. other than "natur rent, the Medical	Completed	15. Decedent's E (Specify only highest gr Elemantery/Secondary (0-12)		16e.	Decedent's U. (Give kind of lifa. DO NOT House		rk dona dunng most of working se retired)			ect of the
0 = 0 >	To Be C	17. Fether's Neme (First, Middle, Lest James Belcher)				18. Mother's Name			ne)
end 2 sho eith end A 127 is ma er trauma		19a. Informant'e Neme/Reletionship (Dianne Allison)		19b 43	Mailing Address 14 Lor	i Str	end Number or Run eet, Suit	al Route Number	or, City or Town, 1D 20746	Stete, Zip Code)
permit. Pages 1 end 2 should b Department of Heelth end Ments Important: If Item 27 is marked any injury or other traumatic e once.		20e. Method of Disposition 1X Buriel 2 □ Crametion 3 □ 4 □ Donetion 5 □ Other (Special		20b. Plece of cometer. Arling	Disposition (A y, cremetory of ton Na	leme of r other ple tiona	cem, 12	Dete 2/23/99	Arlingt	City or Town, Stete
permit. Departn Importa any Inju		21. Signeture of Funeral Service Lice			22 Name 600	end Addre	ton Co. Nedy Street	orticia N W	ns" Inc	0011
Physician /Medical Examiner pure personal interest properties in the pure personal per	Examiner	Immediate Cause (Finel disease or condition resulting in death) Sequantially list conditions, if eny, leeding to immediate geuse. Einter Underlying	b	tic gas	consequence o	of):				Onset and Deeth
death certificate be executed e ettending physicien and of for use es the buriel-transit	edicai	ceuse. Enter Underlying Cause (Olsaase or Injury thet initiated evants resulting in deeth) Last	c	ue to (or es e c	consequance o	f):				
the ette	Physician/M	Part II. Other significant conditions of	contributing to death but	not resulting in	the underlying	g cause giv	ven in Pert i.	23b. Did	tobacco use co	ntribute to the cause of death
E > 8								10	Yes 2 No	3 Probably 4 Unknow
aw requir s been s 2 should	Completed by							24e. Wes	en autopsy rmed?	24b. Wera eutopsy findings eveilable prior to completion of ceuse of deeth?
The ate h								10,	Yas 2 No	1 ☐ Yes 2 ☐ No
Physician: The this certificate ral director, pag	To Be	25. Was cese referred to medicel exeminar? 1 ☐ Yes 2 ☑ No	Hospitel:	t 2 ER/Ou	tpetient 3	DOA Oth	26. Place of Deet	-	ona) dence 6 □Oth	er (Specify)
I or Attending Phy i after death. I Director: After this d in by the funeral d		27. Manner of Deeth 1 Naturel 5 Pending 2 Accident investigatio	28e. Deta of Injury (Month, Dey	28b. T	ime of njury M	28c. Inju			now Injury occur	
or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be datamined	28a. Place of Injur building, etc.	y - At home, fe (Specify)	rm, streat, fact	ory, office		28f. Location (S City or To		per or Rural Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical	29a. Certifiler 1	ysician: To the best of niner: On the besis of a end manner state	xamination and	, deeth occurre d/or investigeti	ed et the til on, In my d	me, data end plece, oplnion, daath occurr	end due to tha ed at the tima,	ceuse(s) end me dete end place,	enner es steted. and due to the ceuse(s)
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		30. Name and address of person who Kenneyh L. Abbatt	complated couse of da			۔ ما ،	B(0 A-1-	E AFB	uD Zoc	62-6600
0.	te	31. Dete filed (Month, Dey, Year)	32. Registrer	's Signeture		rocks		E Pro	2011	4× - C0 00



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death Month

1. Decedent's Neme (First, Middle, Last) 3. Time of Death **Physician** HAROLD GILL /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4RUNDE GIEN BURNIE If Under 1 Year COUNT DRTH If Under 24 Hrs. 9. Birthplaca (Stete or Foreign 5. Social Security Number 6 Sex Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Euperal** Deys Months Hours Country) ENGLAND 1⊠M 2□ F 94 190-09-7126 10, Director Usual Rasidence of Decedent 10a State 10b. County 10d. Inside City Limits 10c. City. Town or Location 28a-f ahow the Medical Examiner must be notified at MD ANNE ARUNDEL SEVERNA PARK 1 Yes 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 41 WEST McKINSEY ROAD 21146 USA "natural", or items 23a Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No1 9 4 3 If Yes, Give Year or Dates: 1 9 4 6 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Morital Status 14. Race · American Indien. Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 🖾 No Specify: Specify: WHITE ò 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiene. 12 ENGINEER MANUFACTURING Important: If Item 27 le marked other eny injury or other traumatic event, 17. Fether's Neme (First, Middle, Last) Maryland 18 Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be 1 nent of Health end Mental HERBERT GILL ZILLAH RICHARDSON 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code) 19e. Informant's Name/Raletlonship (Type, Print) KENNETH R. GILL (SON) 653 SEVERN RD. SEVERNA PARK, MD 21146 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State MARYLAND VETERANS CEMETERY12-22-99 CROWNSVILLE, MD AT CROWNSVILLE 1 N Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 □ Donation 5 □ Other (Spec 22. Name and Address of Facility NES-RINALDI 11800 NEW HAMPSHIRE AVENUE SILVER SPRING, MD 20904 rations that dused the deeth. Do not anter the mode of dying, such as cardiac or respiretory errast, a cause or each line. Approximeta Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examinet physician and the burial-transit that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or es a consequence of): for use a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? PO 1 Yes 2 No 3 Probably Munknown of Vital Records. þ The lew requires 24b. Wera autopsy findings aveileble prior to completion of cause of death? Completed 24a. Was en autopsy performed? 1 Yes 20 No certificate 1 ☐ Yes 2 ☐ No 25. Wes case rafarrad to medical exeminer? Be 26. Place of Deeth (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No 212 ER/Outpatient 3 DOA 1 Inpatient this 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? After n 24 hours after deeth.

Ne Funeral Director: Aft
pletely filled in by the ful 1 ☐ Yes 2 ☐ No

Division or Attending Hospital within 24 hor To the Fune completely fi

Certification: 5 Pending investigation 2 Accident 6 Could not be datarmined 3 ☐ Suiclde 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) Placa of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at tha tima, data and place, and dua to the causa(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

Rd Severna 31. Date filed (Month, Dey, Year)

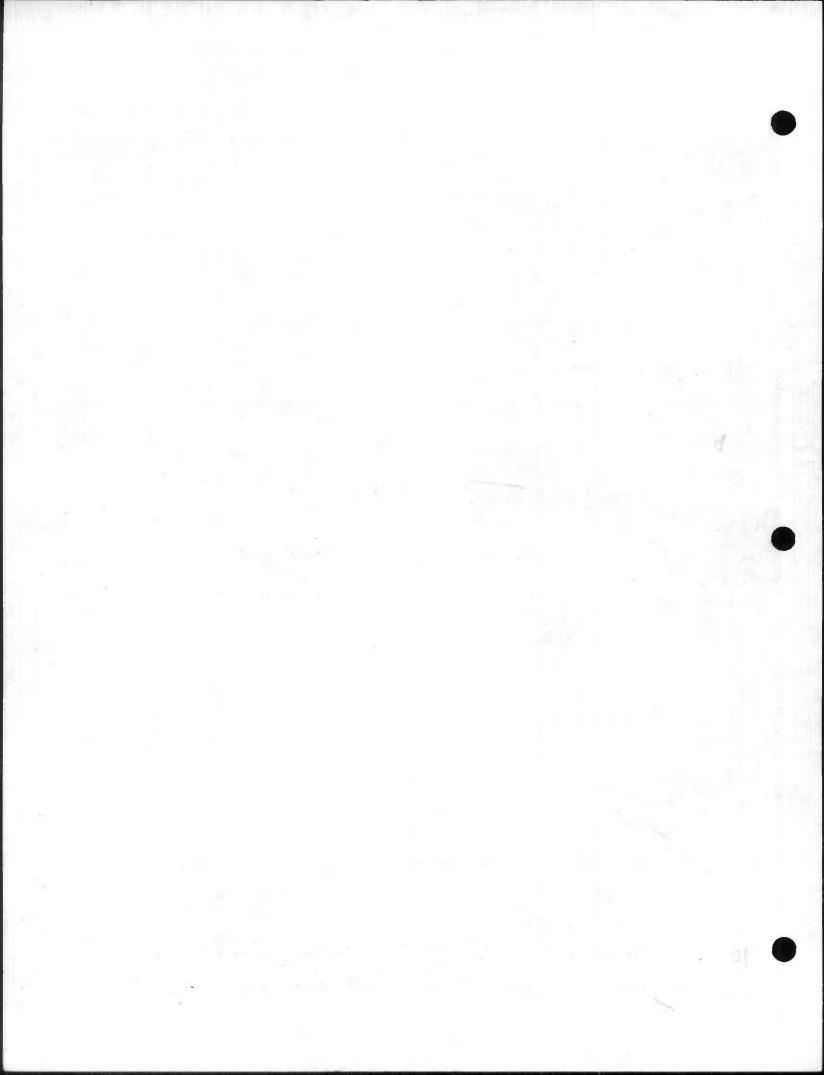
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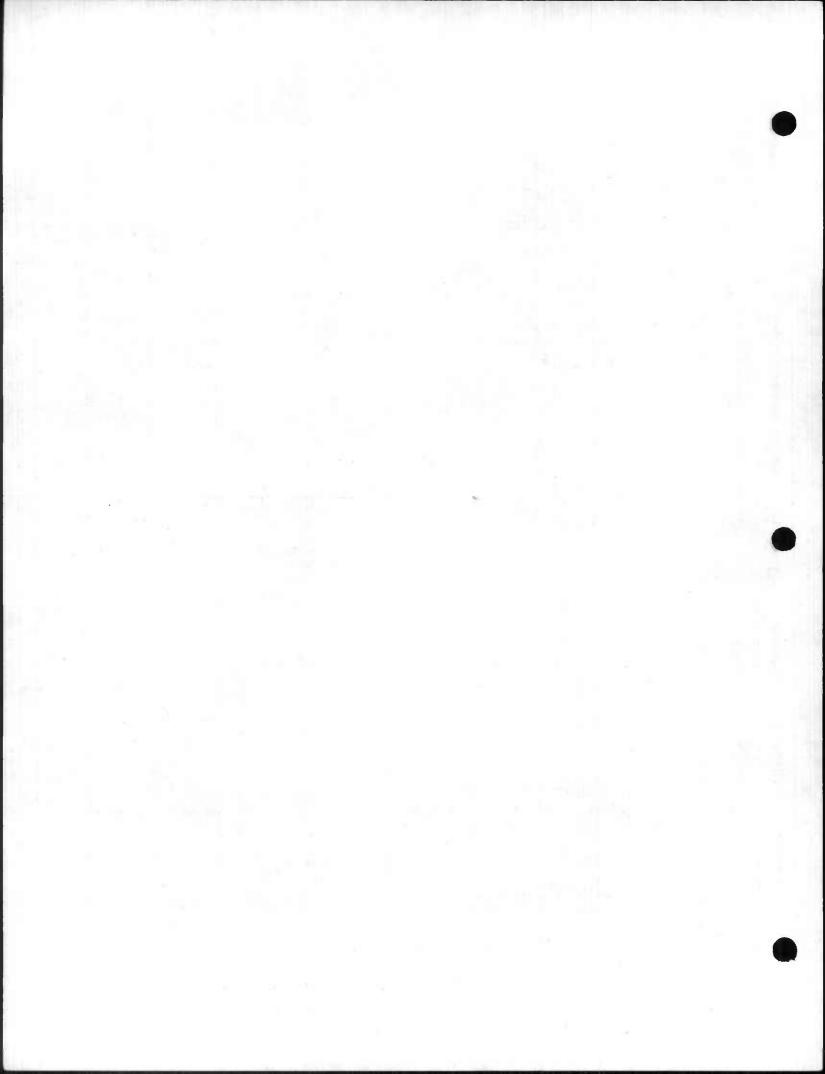
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedenl's Nama (First, Middle, Last) 2. Dala of Death 3. Tima of Death Day Month Year **Physician** ABRAHAM 8,25 AM STANLEY GOLDSTEIN 1999 12 14 /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 513 BRADFORD DRIVE ROCKVILLE MONTGOMERY If Under 24 Hrs. If Under 1 Yaar 8. Data of Sirth (Month, Day, Year) 03.07.1933 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days Months 1 X 2 □ F Yrs. 66 NY Director 112.24.5083 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. inside City Limits ahow r than "natural", or flores 23a or 28a-f ahov the Medical Examiner must be notified at 1 X Yas 2 No Director MD MONIGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 513 BRADFORD DRIVE 20850 USA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? within 72 hours after 1 Nevar Married 2 Married 1 XYas 2 No KOREAN Baltimore, Maryland 21215-0020 WHITE 1 Yes 2 No Specify: If Yes, Give Year or Dales: Specify: PY 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ DOCTOR MEDICAL 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) permit. Pages 1 and 2 should be filk Department of Health and Mental Ly Important: if Item 27 is marked oth any Injury or other traumstic event page. Be RACHEL FREIMAN MAX GOLDSTEIN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 513 BRADFORD DRIVE, ROCKVILLE, MARYLAND BODIL P. GOLDSTEIN/WIFE 20b. Place of Disposition (Name of 20a. Mathod of Disposition Date 20c. Location - City or Town, State cemetery, cremetory or other place) 1 Burial 2 Cramation 3 Removal from State 4 ☐ Donalion 5 ☐ Other (Specify) PARKLAWN/MENORAH GARDENS 12/19/99 ROCKVILLE, MARYLAND 21. Signature of Funeral Se 22. Nama end Address of Facilit EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximete interval Between Onset and Deeth **Physician** /Medical Immediata Cause (Final METASTATIC RSOPHAGEAL ADENOCARCINOMA 6 MONTHS disaase or condition resulting in death) **Examiner** Due to (or as a consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760. Physician/Medical Due to (or as a consequence of): for use as 88 980 P.O. signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yee 2 | No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy Deed page 2 s 1 Yes 2 No 1 Tyes 2 No certificate of Vital or Attending Physician: 25. Was case referred to medical B 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpalient 2 ER/Oulpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Time of After Division 1 Nelural 5 Pending death. 1 Yes 2 No investigation 2 Accident Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) after 4 Thomicide vithin 24 hour within 24 hours aft To the Funeral Dil completely filled In 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicat Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certified La MD 21845 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INGHAM, JANE M 3800 RESERVOIR RD, NW, WASHINGTON, DC 20007-2197 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 20 Jepera Registrar

DHMH 16 Rev 6/95

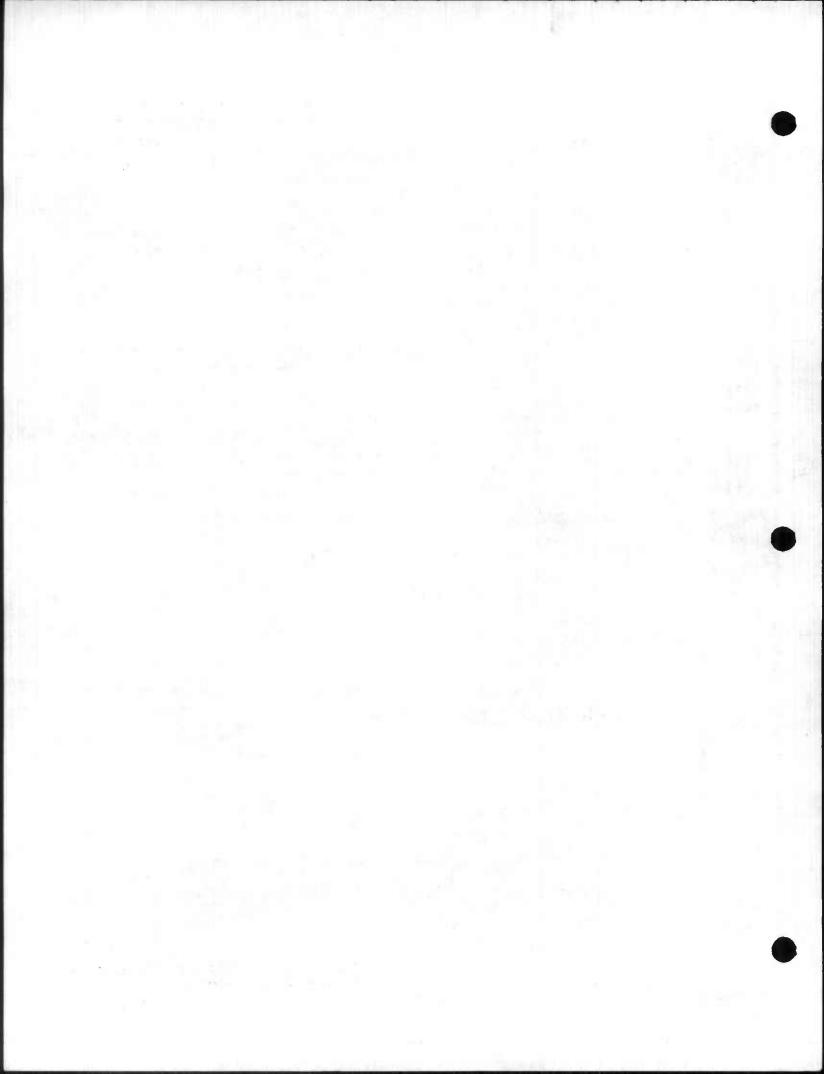


Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

99 41802

		oraco or maryle	Cert	tificate of	Death		leg. No.	2 41002
Dharatalan	1. Decedent's Nama (First, Middle, La	st)				2. Data of Des Month		3. Time of Death
Physician /Medical	EMIL LEWIS	GRASSIA				Decembe	er 25 19	99 7:58pm
Examiner	4e Facility Nama (If not institution, given	e street and number)			4b. City, Town, or	Location of Death	4c. County o	f Death
	Civista Medical	Center			LaPlata		Char1	es
Funeral	5. Social Security Number 6. S	Sex 7. Aga (In y	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Data of Birth (Month, Day CT • 10	Year)	9. Birthplace (State or Foreign
Director	447-34-0301	XM 20F 4	6 Yrs.			qcT.10;	1953	MARYLAND
2 .	Usual Rasidanca of Decedant 10a. Stata 10b. County	100	City. Town or Loc	ntion				10d. Inside City Limits
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# 88 D	10a. Street and Number 3241 RYON COURT			10f. Zip Code	0601		10g. Citizen of Wi U • S	
flor death reflece 23 siner must	11. Marital Status	12. Was Decedent Ever in Armed Forcas?	U,S. 13. W	as Decedent of I	Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14. Race Black	- American Indian, Whita, etc.
orn at or at	1 Nevar Married 27 Merried 3 Widowed 4 Divorced	1 ☐Yes 2 ☐ No If Yes, Give Yaar or Datas: 19	1	☐ Yes 2☐No			Specify:	WHITE
21215-0 ed within 72 ha ygiena. Ar than freturn At the Medical. Completed	15. Decedant's E	ducation	16a Decede	16a Decedent's Usual Occupation			16b. Kind of Bus	iness/Industry
wmin with the state of the Media	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retire	during most of world)	KING		
Non man	Theoretic variables	1	HOME	IMPROV	EMENT O	WNER	CONSTR	UCTION
Be south Be	17. Father's Nama (First, Middle, Last)			18. Mother's Nan	ne (First, Middle,	Maiden Sumame)
The Heart of The State of The S	EMIL LEWIS F	'ERRAND			COR	INNE GF	RASSIA	
ary sho	19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing	Address (Street	t and Number or Ru	iral Route Numbe		
	ANN GRASSIA -	SPOUSE	6405	WARREN	C. ELL	ER DRIV	E LA	PLATA, MD 20646
0 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	20a. Mathod of Disposition		. Place of Dispos	ition (Name of atory or other pla	ice)	Data	20c. Location - C	City or Town, State
Pages Pages married my or o	1 Burial 2 Cremetion 3 C	JRemovel from State ME'			EMATORY	12-29-	99 ALE	XANDRIA, VA.
Saltimore, semit. Pages 1 s. Department of Hea mportant: if tem inty injury or other inter.	21. Signature of Funeral Service Lice			Name and Addr				
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Physician /Medical	Immediale Cours /Final	-						Onsot and Dodgin
Examiner	Immediela Ceusa (Final disaasa or condition resulting in death)	a. RESPI	R'A TOF	RY F	AILUK	E		
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and I-tran	Sequentially list conditions,	Dua to	(dras a consequ	ence of):				
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oc rou, filcate be executed physician and as the burlat-transit	that initiated evants rasulting in death) Last	Dua to	(or as a consequ	ence of):				
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sic sec	Part II. Other significant conditions of	ontributing to death but not r	resulting in the un	derlying cause gi	ven in Part I.	23b. Did t	obacco use cont	ribute to the cause of death?
dS, F.O. BOX ires that the death cert signed by the attendin d be detached for use d by Physician/M	Crophas	20 71	1 140	0		101	(08 2)K No	3 Probably 4 Unknown
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DIVISION Cate of the country of the	3 ☐ Suicida 6 ☐ Could not b	e Diese of Injury At	t homa farm stree		7.3	28f. Location /S	treet and Numbe	r or Rural Route Number,
Pare Line	4 Homicide datamined	building, etc. (Spe	ecify)	.,,,		City or Ton		
\$ 5 ± 0	29a. Certifiar 12 Certifying Ph	ysician: To the best of my k	nowledge, death	occurred at the ti	ima, data and place	, and due to the c	ause(s) and man	ner as stated.
he Hospi in 24 hou he Funer pletely fil edical	one) 2 Medical Exar	niner: On the basis of axami and manner stated.	HIGHOT BROYOF WIVE	sougation, in my	uprimum, death occu	med at the time, t	ante anto piace, at	TO GUE TO BIR CHUSE(S)
Within to the complete of the	29b. Signatura and titla of certifiar		1.0	29c. Licen	se number			(Month, Day, Year)
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	30. Name and address of person who	complated causa of death (iii	tem 23a) (Type P		5 & Golde	n Beach		
	Vidyasagar Anma		=04/ (1900)		lotte Hal			
State	31. Data filed (Month, Day, Year)	32. Registrar's Sig	natura	4		I, IIII y I	und 2002	•
Registrar	DEC 2 9 1			Some	1/2/			



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-			nber)				4b. City, To	wn, or L		1		h	_
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Usual Rasidanca of	Decedent												
10a. Stata													da City Limits
Maryland	Prince	George's	U	niversi	ty P	ark						1.5	Yes 2□No
10e. Street and Nur 6908 We11		ıy			10f. Zi		782					untry?	
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		9		Prot	esso	r				Educati	Lon		
	•										ma)		
19e. Informant's Na	ama/Ralationship	(Type, Print)		19b. Mailin	g Addras	s (Straa	and Numb	er or Rui	al Routa Numb	er, City or Town	, Stata, 2	(ip Code)	
Richard	A. Good	- Husban	d	6908	Well	s Pa	rkway	. Ur	iversi	tv Park	MD	2078	2
	□Cramation 3 l		State	Placa of Dispos camatary, cram	sition (Na natory or	ma of othar pla	ice)		Data	20c. Location	- City or	Town, Sta	nta
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Part II. Other signif	ficant conditions	contributing to de	ath but not ra	suiting In the ur	ndarlylng	causa g	van in Part	t.	23b. Did	tobacco use c	ontribute	to the co	suse of death?
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									1 🗆	Yas 2 No		1 🗆 Yas	2 No
25. Was casa refar	red to medical						26 Plac	a of Daa	th (Check only	-	1		

Physician /Medical **Examiner**

attending physician end for use es the burial-trensit

sate hes been signed by the page 2 should be detached

After this certificate

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director,

The law requires that the deeth certificete be executed

Division of Vital Records, P.O. Box 68760,

Examiner

Physician/Medicai

Completed by

Be

Certification: To

Medicai

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Peges 1 and 2 should be filed within 72 hours efter deeth with the Maryland

Baltimore, Maryland 21215-0020

Department of Health and Mental Hygiene. It invaris error usern with the Maria Hygiene. Important: if fram 27 is marked other than "natural", or frems 23s or 28s-4 show any injury or other traumatic event, the Medical Examines must be notified at once.

25. Was casa refarred to medical axaminar? 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28b. Tima of

27. Mannar of Daath 1 Natural 5 Pending Invastigation 2 Accidant 6 Could not be datermined 3 Suicide 4 Homicide

and title of certif

28a. Data of Injury (Month, Day Year)

Placa of Injury - At homa, farm, streat, fectory, office building, etc. (Specify)

Othar: 4☐ Nursing Home 5 Rasidance 6 ☐ Other (Specify) 28d. Dascribe how injury occurred

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

December 21, 1999

1 Certifying Physician: To the bast of my knowledge, death occurred et the time, deta and plece, end due to the ceusa(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the ceuse(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

30. Name end eddress of person who complated cause of death (Itam 23a) (Type, Print)

Kenneth W. Hauck, M.D. 2415 Musgrove Road, #203, Silver Spring, MD 20904

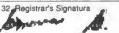
0 State

31. Deta filad (Month, Day, Year)

29a. Certifier (Check only one)

29b. Signatu

DEC 2 2 1999





28c. fnjury at Work?

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Time of Death DECEMBER 16,1999 11:20pm NUGENT HORACE GIBSON 4b. City, Town, or Location of Daath 4c. County of Death 4a Facility Nama (If not institution, giva street and number) MONTGOMERY MONTGOMERY GENERAL HOSPITAL If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) JAN 24, 1909 9. Birthplaca (Stata or Foraign 7. Aga (In yrs. last birthday) 10XM 2□ F Months Days Hours MONROVIA LIBERIA 90 Yrs. 10c. City, Town or Location 10d. Inside City Limits Was 2 No BALTIMORE 10f. Zip Coda 10g. Citizen of What Country? LIBERIA

Funeral Director

Physician

/Medical

Examiner

1. Decedant's Nama (First, Middla, Last)

5. Social Security Number

10a. Stata

Usual Rasidanca of Dacadant

10b. County

the Marylend r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at with

Depart i. Peges 1 and 2 should be filed within 72 hours after death vegeperment of Health and Mentel Hygiene. Important: if flem 27 is marked other than "natural", or flems 23 any Injury or other traumatic event, its Medical Examination must ender a bottom.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

certificate be executed

Box 68760.

P.O.

Division of Vital Records.

attending physician end for use es the bunel-transit the signed by hes this funerel After t al or Attending F s efter deeth.

Examiner Physician/Medical by Completed Be Certification: To 6 Medical To the Hosp within 24 hou To the Fune completely fi

MD Director 10e. Street and Number 21223 605 SOUTH SMALLWOOD ST. Funeral 12. Was Dacedant Evar In U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 14. Race - Amarican Indian, Black, Whita, atc. Was Decadent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 □ Navar Married 2 □ Married Specify: BLACK 1 Yas 2 No Specify: by 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grada completed) Elementary/Secondary (0-12) Collega (1-4or 5+) PRIVATE EXECUTIVE MANAGER 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Fathar's Nama (First, Middle, Last) PAULINE HICKS NUGENT HORATIO GIBSON 19b. Malling Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 3129 BEAVERWOOD LANE, SILVER SPRING, 20906 CHARLES COOPER / NEPHEW 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 12-30-99 MONROVIA, LIBERIA 4 □ Donation 5 □ Othar (Spacify) MONROVIA CEMETERY 22. Nama and Address of Facility. POPE FUNERAL HOME 21. Signatura of Funaral Sarvice Licensee 23a. Part1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or haan failure. List only one cause on each line. 11315 LOCKWOOD DRIVE, SILVER SPRING, MD Approximata Intarval Between Onsat and Death RESPIRATORY FAILURE tmmadiata Causa (Final disaasa or condition rasulting in daath) Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Impatiant

28a. Data of Injury (Month, Day Year)

Hospital:

24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 28. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 28d. Dascribe how injury occurred 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

28a. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 29a. Cartifiar 1 Cortifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated 2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certific 29d. Data signad (Month, Day, Year)

28c. Injury at Work?

1 Yas 2 No

2 ER/Outpatient 3 DOA

28b. Tima of

24 hours e

Registrar

31. Data filad (Month, Day, Yaar) DEC 2 1 1999

30. Nama and addrass of person who completed cause of death (Itam 23

5 Panding invastigation

6 ☐ Could not be detarmined

25. Was casa refarred to medical axaminar?

1 Yas 2 No

27. Mannet of Daath

1 Natural

2 Accidant

3 ☐ Suicida

4 Homicida

32. Registrar's Signatura

#328, Claty, mo

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THE SHARK LIVE SALE

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day Yaar **Physician** 3:56 AM 1999 DELORES V. GROSS 16 12 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Prince George's Community Hospital Cheverly If Undar 24 Hrs Prince George's If Undar 1 Year 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 🖾 F Director 64 Wash., DC 578-46-8295 3-01-1935 Usual Rasidanca of Decedan with the Marylend 10d. Insida City Limits 10a. Stata 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Medical Examiner must be notified at TX Yas 2 □ No Directo Prince George's Cheverly 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 20785 USA 6519 Landover Road #101 Funeral death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Dates: 14. Race - Amarican Indian, Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 11. Maritel Status Black, White, etc. permit. Peges 1 end 2 should be filed within 72 hours efter of Department of Heelth and Mental Hygiana. In procrant: If fem 27 is marked other than "natural", or ther eny injury or other treumatic event. The second in the seco 1 ☐ Nevar Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Wash. Hosp. Center Nurse 12 18. Mothar's Nama (First, Middla, Maldan Sumama) 17. Fathar's Nama (First, Middla, Last) Verdie Johnson Leroy Henderson 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) 6519 Landover Rd., Charles Gross/husband #101 Cheverly, MD 20785 20b. Placa of Disposition (Nama of cematary, cramatory or other placa) 20e. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) 12/22/99 Fort Lincoln Cemetery Brentwood, MD 22. Name and Addrass of Facility 21. Signeture of Funerel Servica Licansee Tyrone J. Young Funeral Services 719 Kennedy Street, NW Wash., DC 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. 20011 Approximate Intarval Between Onsat and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in daath) /Medical Examiner Examiner the death certificate be executed and buriel-tran Sequantially list conditions, if any, laading to Immadiata causa. Entar Undarlying Cause (Disaasa or Injury that initiated evants rasulting in daath) Last a to (or as a consaquanca of): physician s the buriel Physician/Medical Due to (or as a consequanca of): SB USB 0 23b. Did tobacco use contribute to the cause of death? deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown ò 24b. Wara eutopsy findings evailabla prior to complation of cause of daath? Completed 24a. Was an autopsy performed? peen hes page 2 2 No 1 Yas certificate Hospital or Attending Physician:
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 Funeral Director: After this certific funerel director, Be 25. Was casa refarred to medical axaminar? 26. Placa of Death (Check only ona) Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 20 2 ER/Outpatient 3 DOA P 1 Yas 1 Inpatiant 27. Mapner of Death 28a. Data of Injury (Month, Day Yaar) 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred 5 Panding 1 Yas 2 No invastigation 2 Accidant 6 Could not be datarmined 3 Suicide 28e. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 28f. Location (Streat end Number or Rural Routa Number, City or Town, Stata) 4 - Homicida 29a. Cartifier Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, date and plece, and dua to tha ceusa(s) and menner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) Within 2 To the and mannar statad. 29c. License number 29b. Signatura a 29d. Data signed (Month, Da

State Registrar

Meera Kanhouwa, 31. Data filed (Month, Day, Year)

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30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

3001 Hospital Drive Cheverly, Maryland 20785

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32. Ragistrar's Signatura

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To the Funceal Director: After this certificate has complately filled in by the funeral director, page 2 Medical Certification: To Be Comp	29b. Signatura and title of bertiller. 30. Nama and address of person who John J. Kelly, J	o completed cause of death	(Itam £3a) (Typ	Print)	19267	DiG	12/	22/9	5	

[•] Registrar

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State of Maryland / Department of Health and Mental Hygiene

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Physician // Medical Examiner Patrick Horace Gates 4 Facility Name (Frat. Medic, Last) Patrick Horace Gates 5 Social Security Number 6 Social S
Patrick Horace Gates Examiner Funeral Director
Scale Name (I not institution, give streat and number) Southern Maryland Hospital Funeral Director Southern Maryland Hospital 10 South Security Number 2 1 August 8, 1942 Maryland Southern Maryland Hospital 10 South Security Number 2 1 August 8, 1942 Maryland 10 South Security Number 2 1 August 8, 1942 Maryland 10 South Security Number 2 1 August 8, 1942 Maryland 10 South Security Number 2 1 August 8, 1942 Maryland 10 South Security Number 2 1 August 8, 1942 Maryland 10 South Security Number 2 10 Coley, Town or Location Waryland Charles Waldorf 10 Size and Number 1 10 Coley, Town or Location Waryland Charles Waldorf 10 Size and Number 1 10 Coley, Town or Location Waryland Charles 10 Coley Town or Location Waldorf 10 Size and Number 1 10 Coley, Town or Location Waldorf 10 Size and Number 1 10 Coley, Town or Location Waryland Charles 10 Specify only in Specify 1 Specify Specify Year or No- 11 Marial Status 1 10 Coley Town or Location Waldorf 10 Size and Number 1 10 Coley, Town or Location Waldorf 10 Size and Number 2 10 Coley Town or Location Waryland Charles 10 Number Mariad Status 1 10 Coley Town or Location Waryland Charles 11 Merial Status 1 10 Coley Town or Location (Dyne Specify only in Specify Coley, Measlow, Puerto Rican, etc.) 11 News Mariad Status 1 10 Coley Town or Location (Specify only injmest grade complated) 11 News Specify White 12 Number Decedents Education (Specify only injmest grade complated) 12 Number Specify Coles, Measlow, Puerto Rican, etc.) 13 Number Decedents Education (Specify only injmest grade complated) 14 Specify Specify War or Dottes 15 Decedents Education (Specify only injmest grade complated) 16 Decedents Education (Specify only injmest grade complated) 17 Father's Name (First, Middle, Last) 18 Decedents Education (Specify only injmest grade complated) 19 Decedents Education (Specify only injmest grade complated) 10 Decedents Education (Specify only injmest grade complated) 10 Decedents Education (Specify only injmest grade
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Director Page Page
Usual Residence of Decedent 10s. States 10b. County 10s. Street and Number 2460 Hanover Ct. 2460 Hanover Ct. 2460 Hanover Ct. 11. Was Decedent Ever in U.S. Almed Forces? 11. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, 17. County of Specify: White States 10b. County of Specify: White States 10b.
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15. Decedent's Education (Specify only highest grade complated) Elementery/Secondary (0-12) 12th N/A Administrator 16. Mother's Name (First, Middle, Maiden Sumeme) Pearl Elizabeth Daniels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1 Storage of Disposition (Name of Commentery) 1 Storage of Disposition (Name of Commentery) 20a. Method of Disposition 1 Storage of Disposition (Name of Commentery) 21. Signature of The Name (First, Middle, List) 22. Name and Address of Facility 22. Name and Address of Facility 23a. Part Enter the disease, or committee of each line. Physician (Medical Examiner) Physician (Medical Examiner) 22a. Part Enter the disease, or committee of each line. Physician (Medical Examiner) 25a. Part Enter the disease, or committee of each line. Physician (Medical Examiner) 25a. Part Enter the disease, or committee of each line. Physician (Medical Examiner) 25a. Part Enter the disease, or committee of each line. Physician (Medical Examiner) 25a. Part Enter the disease, or committee of each line. Physician (Medical Examiner) 25a. Part Enter the disease, or committee of each line. Physician (Medical Examiner) 25b. Place of Disposition (Name of Commentery) 25c. Location - City or Town, State of each line. 25c. Location - City or Town, State of each line. 25c. Location - City or Town, State of each line. 25d. Disposition (Name of Commentery) 25d. Part Enter the disease, or committee of each line. 25d. Part Enter the disease, or committee of each line. 25d. Part Enter the disease, or committee of each line. 25d. Part Enter the disease of condition resulting in death) 25d. Part Enter the disease of condition resulting in death) 25d. Part Enter the disease of condition resulting in death) 25d. Part Enter the disease of condition resulting in death) 25d. Part Enter the disease of condition resulting in death) 25d. Part Enter the disease of conditions that caused the de
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17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme)
17. Father's Name (First, Middle, Last) John Cornelius Gates Pearl Elizabeth Daniels 19a. Informant's Name/Relationship (Type, Print) Joanne Gates (Wife) 20a. Method of Disposition 1
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27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Dey Year) 28b. Time of tnjury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred
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3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 5 Could not be datermined building, etc. (Specify) 5 Each of Injury - At home, farm, street, factory, office building, etc. (Specify)
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. (Check only (Ch
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated.
and manner stated. 29c. Licensa number 29d. Data signed (Month, Dey, Year)
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30. Name and address of person who from placed cause of death (Item 23a) (Tune Print)
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Suite 201
30 Name and address of person who from place theuse of death (Item 23s) (Type Print)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death December 17,1999 **Physician** ROY **EDWARD** HALL Sr. 2:55pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6528 Damascus Rd. Gaithersburg Montgomery If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year) April 4,1930 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1X M 2 F 69 579-38-2179 Yrs. Kentucky Director Usual Residence of Decedent Marylend 10a. Stata Md. 10b. County Montgomery 10c. City, Town or Location Gaithersburg 10d. Inside City Limits items 23s or 28s-f show ther must be notified at 1 ☐ Yas 2 🗓 No Director the th 10e Street and Number 10f Zin Code 10g. Citizen of What Country? with 6528 Damascus Rd. 20882 United States Funeral deeth Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Statue filed within 72 hours after. Hygiene. other than "natural", or its 1 Yes 2 No
If Yes, Giva
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 ☐ Yaa 2 X No Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: if Item 27 is marked other tha eny Injury or other traumatic avent, that phos. Medical Technician Health Care 10 17 Father's Name (First Middle Last) 18 Mother's Nama (First Middle Maiden Surnama) 8 Burnette Abraham Hall Teresa Sexton 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Opal Marie Hall (Wife) 6528 Damascus Rd. Gaithersburg, Md. 20882 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 21, Rockville, Md. Parklawn Memorial Park 22. Nama and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licens wites 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death Physician Immediata Cause (Final disease or condition resulting in death) /Medical Conjestive Heart Disease 2 Years Examiner Due to (or as a consequence of): Examiner Coronary Artery Disease 15 Years physician and the burial-transit the deeth certificate be axecuted Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Mitral Valve Prosthesis 20 Years Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): 680 ğ P.0. Part If. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? the 6 1 N Yes 2 No 3 Probably 4 Unknown Records, by The law requires 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy has page 2 1 ☐ Yes 2 XNo 1 ☐ Yes 2 No certificate Division of Vital Physician: director, 25. Was casa referred to medicat examiner? 8 26. Placa of Death (Check only ona) To. Hospital: Other: 4 ☐ Nursing Homa 5 N Residence 6 ☐ Othar (Specify) 1 Yas 2 No 1 Inpetient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) Director: After this in by the funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? Certification: al or Attending F s efter death. 1 Naturel
2 Accident 5 Pending investigation 1 □ Yas 2 □ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital or A within 24 hours effer To the Funeral Director Completely filled in by 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) Mourin evvett D47682 8 December 18, 1999 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Bennett T. Morrison M.D. 2901 Olney-Sandy Spring Rd. Olney, MD. 20832

State Registrar

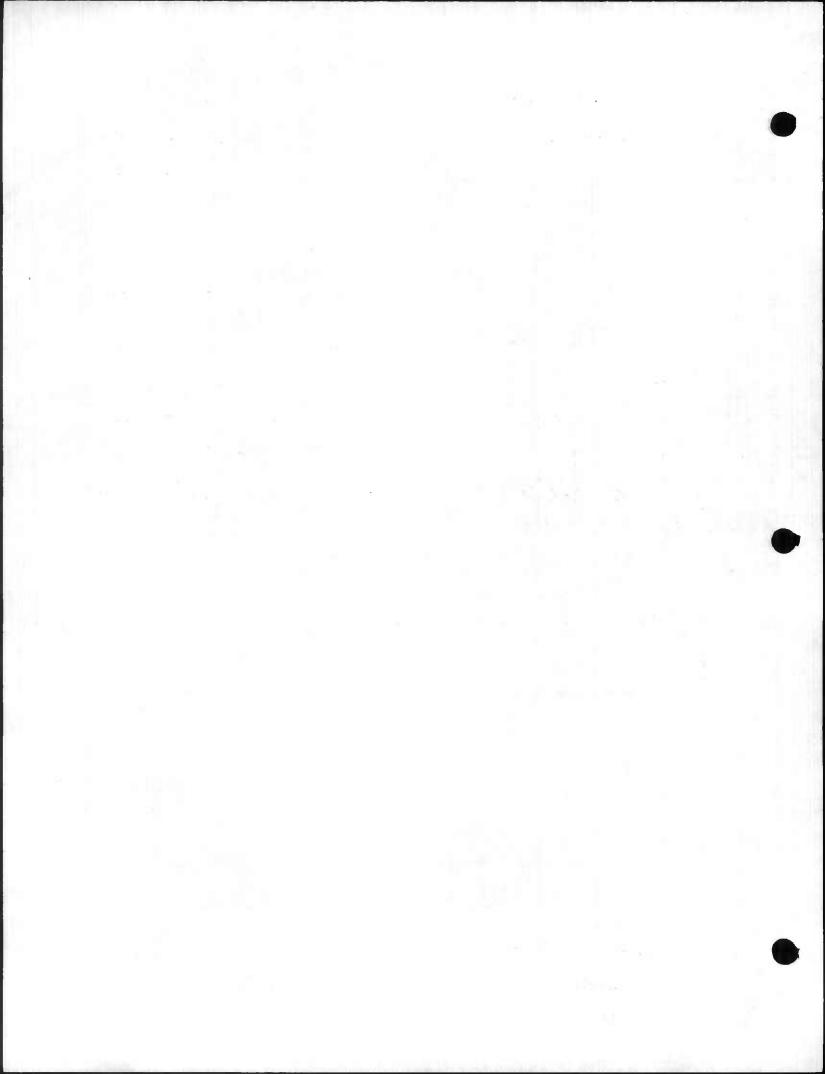
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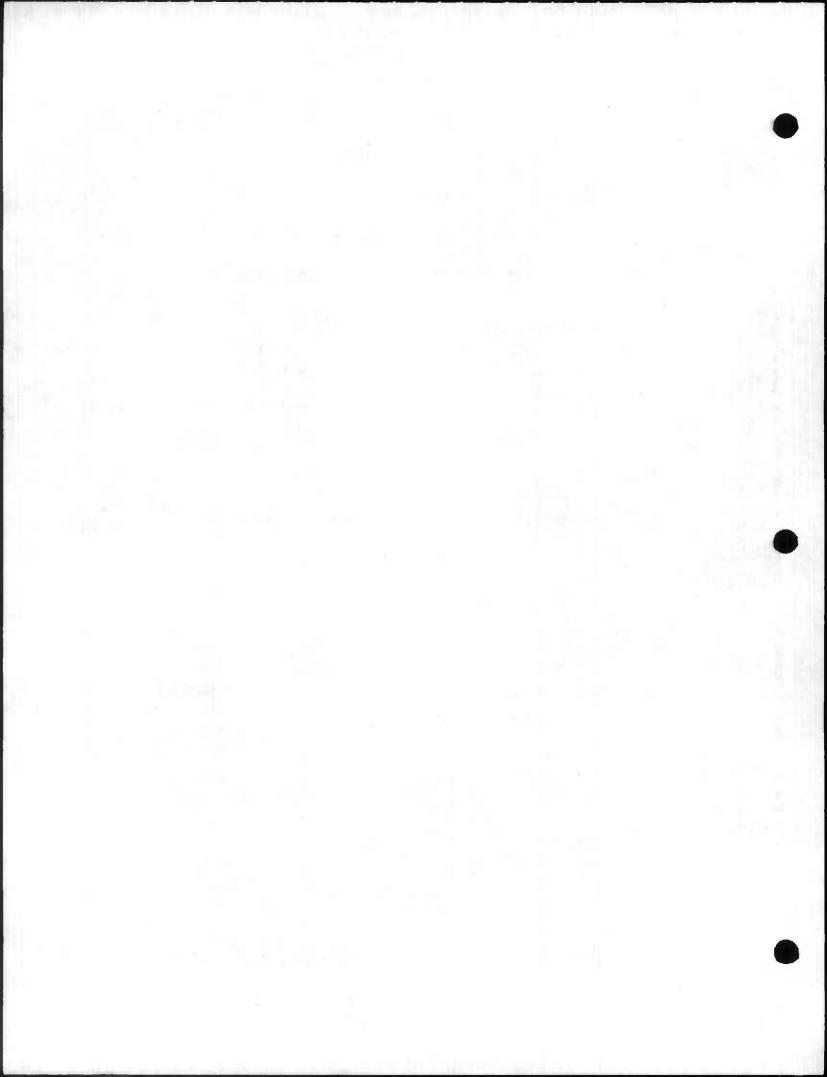
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32. Registrer's Signatura



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				,	Certific		Death		Reg. No.	14	1809
ian	Decedent's Name (First, Middle							2. Date of Do Month	Dey	Yeer	3. Tima of Death
cal	Rosemary H								er 19, 1		2:00 PM
ner	4a Facility Name (If not institution						4b. City, Town, or			of Death	
	Montgomery Vill	age Care	_				Montgomer			gomer	
	5. Social Security Number	6. Sex 1 ☐ M 2 ☒ F		(In yrs. last b	Mon	nder 1 Year ths Days		8. Date of Bi (Month, D.	rth ay, Year)	9. Birthp	piaca (Stete or Foreign
	578-26-2483	ILIM ZWIT		83	Yrs.			December	3, 1916	Penns	sylvania
	Usual Residence of Decedent			10a City Tay	on as I continu						Od Inside Charling
	10a. Stete 10b. County				wn or Location	7.11				τ	0d. Inside City Limits
	Maryland Montg	omery		Montg	omery V	/illag	ge				1 ☐ Yes 2 X No
	10e. Street and Number				106	Zip Code			10g. Citizen of V	Whet Coun	ntry?
ı	19301 Watkins M	Iill Road	l			2	20886		United	State	es
-	11. Maritel Status	12. Was De	cedent Ev Forces?	ver in U,S.	13. Was D	ecedent of I	Hispanic Origin? (S can, Mexican, Puer	specify Yes or No		a - Americ ck, White,	
	1 Never Married 2 Marr		2 NO			s 2 No			Specify		
	3 ☑ Widowed 4 ☐ Divorced	Year or				- 192.10	opolity.		Speciny	Whi	Lte
ĺ	15. Deceden (Specify only higher	's Education	d)	16	. Decedent's	Usuel Occu	pation	deina	16b. Kind of Br	usiness/Ind	dustry
I	Elementary/Secondery (0-12)		(1-4or 5+)	life. DO NO	T use retire	during most of wo				
			3		Registe	ered N	Nurse		Med	ical	
	17. Father's Neme (First, Middle,	Last)					18. Mother's Na	me (First, Middle	, Maiden Suman	10)	
	Joseph Sanko						Cather	ine Duni	nigan		
	19a. Informant's Neme/Reletions	hlp (Type, Print)		19	b. Mailing Add	ress (Stree	t and Number or R			State, Zip	Code)
	Mary P. O'Brien	/Daughte	r	13	228 Me	ander	Cove Dri	ve, Ger	mantown,	MD :	20874
I	20e. Method of Disposition			20b. Plece	of Disposition	(Name of	ace)	Date	20c. Location -	City or To	own, Stete
I	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other (S)		m Stete		nery Cre			Dec. 21, 1999		- M-	1
	21. Signature of Funeral Service			Tibritegor					Bethesd	a, Ma	eral Home/
	1//	MA					Chevy Cha				
1	XIT 6			01126	Avenu	ie. Be	thesda.	Maryland	1 20814-		
	23a. Part1. Enter the diseese, or shock, or heert feilure. List	complications the only one ceuse or	t caused to n eech line	he death. Do I.	not enter the	mode of dy	ing, such es cardia	c or respiretory (errest,		Approximete Interval Between Onset and Deeth
										1	Oriset and Deetin
	Immediate Ceuse (Finel disease or condition	. Ve	ntri	cular	Fibrill	Lation	1			I	Immediate
	resulting in deeth)	w	D	ue to (or as a	consequence	of):					
		_ At	hero	sclero	sis					13	30 Years
	Sequentially list conditions,	Ų.	D	ue to (or as e	consequence	of):					
1	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury									1	
ı	thet initieted events resulting in death) Last	C	D	ue to (or as a	consequence	of):				1	
	and a second second										
		d									
	Pert II. Other eignificant condition	ns contributing to	death but	not resulting	in the underlyi	ng cause gi	iven in Pert I.	23b. Did	tobacco use co	ntribute to	o the cause of death?
1	0-11-14-4-43	_1, _ 1						1□	Yes 2 No	3 Pro	bably 4 Unknown
	Cellulitis, Al	zneımer'	s Di	sease							
	Hypothyroidism	1						24a. Wa	s an autopsy ormed?		ere eutopsy findings ailable prior to
	J. J		-					pen	OIIII O UT	co	mpletion of cause death?
1								4.0	Vac allana		Yes 2□ No
ŀ	Atrial Fibrill	ation					44 44		Yes 2 No	11	1 fes ZLI NO
	25. Wes case referred to medical examiner?	Hospitel:					than	ath (Check only			
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	1 Natural 5 ☐ Pendin	g (Mc	e of Injury onth, Dey	Year) 28b.	Tima of Injury	28c. Inju		ZOU. DESCRIDE	how injury occur	190	
	2 Accident investig	ot be			М		Yes 2 No	201 :	(O)		10-11
	4 Homicide determ	ined 28e. Ple	ca of Injur Iding, etc.	y - At home, i (Specify)	erm, street, fe	ctory, office		281. Location City or To	(Street and Numi own, State)	per or Rura	si Houte Number,
							ime, date and place opinion, death occ				
	one)	end me	enner slete	ed.							
	29b. Signeture and title of certifier	21	7	>		29c. Licen	ise number	100	29d. Date signe	d (Month,	Dey, Year)
	· cel	300				Da	23443		Decembe	0,02	0.1999
ŀ	30. Name and address of person	who completed ca	use of dea	ath (Item 23a)	(Type, Print)				2-77-01		-1
	Alan R. Pollac					Road	#101, Roo	ckville.	Marylan	nd 20	851-1689
Ì	31. Dete filed (Month, Dey, Year)	-		's Signeture	1	1					
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State of Maryland / Department of Health and Mental Hygiene

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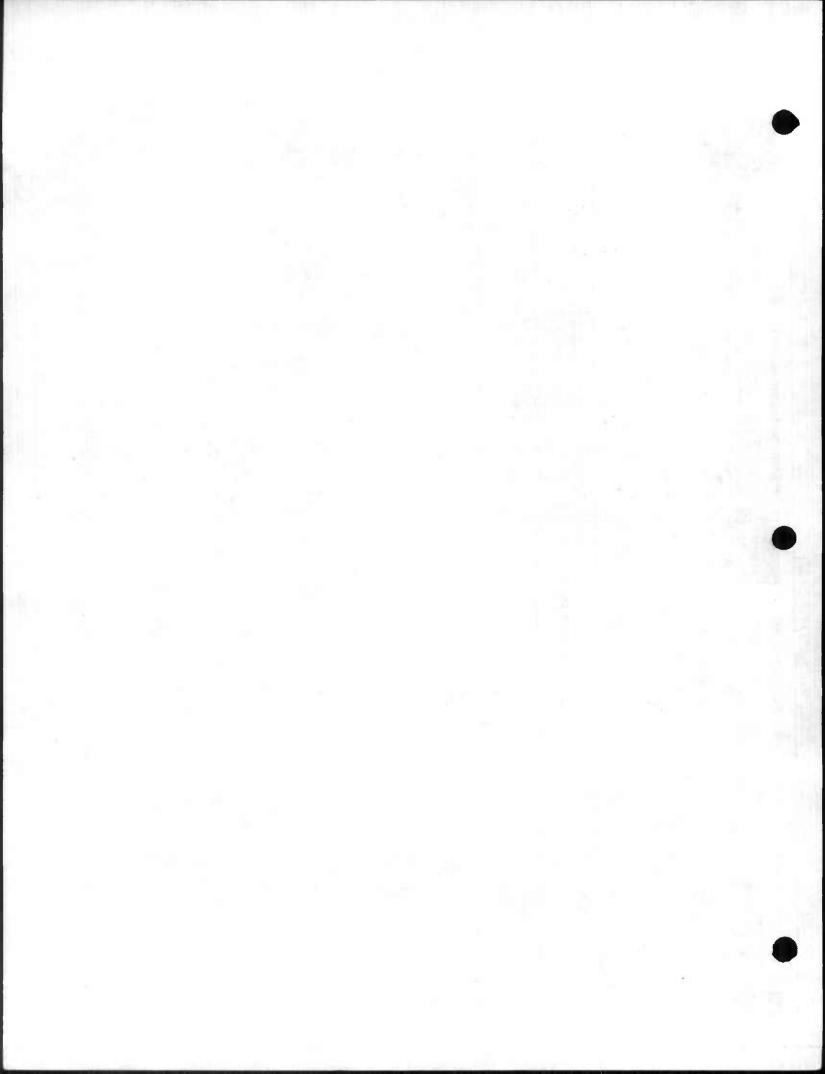
					,	C	ertificate	of	Death	,	Reg. No.		4101U
	Dhusinian	1. Decedent's Neme (Firs	st, Middle, Las	st)						2. Dete of De Month	eath Dey	Year	3. Time of Death
1	Physician /Medical	JOHN H	IIPPCHE	N							ER 17,19		9:05AM
	Examiner	4e Facility Neme (If not in	nstitution, give	street end nur	nber)				4b. City, Town, or L	ocation of Deet	h 4c. County	of Deeth	
		SUBURBAN	HOSPI						BETHESDA			TGOME	
	Funeral Director	5. Sociel Security Number 579–30–2735 Usuel Residence of Dece	1	ex OXM2□F	7. Age (In yrs 71		Months	Year Deys	If Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, Da DEC . 29	ly, Year)		aca (Stete or Foreign ry) INGTON D. (
	death with the Maryland ma 23a or 28a-f show finant be notified at neral Director	10a. Stete 10b.	County IONTGOM	IERY	1	City, Town or	RSBURG					100	d. Inside City Limits 1 ☐ Yes 2 ☒ No
	or 28e-f a	10e. Street and Number			1		10f. Zip (Code		T	10g. Citizen of	What Countr	ny?
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020	or he more	11. Meritel Stetus 1 Never Merried 2 3 Widowed 4 D		12. Wes Dece Armed For 1 Tes If Yes, Giv Year or De	ces? 2 XNo e	U,S. 1	3. Was Decede If Yes, specif		lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Rac Ble Specify	ce - America ck, White, et v: WHI	lc.
0-10	natural,	,15. D	ecedent's Ed	ucation		16a. De	cedent's Usuel	Occup	ation		16b. Kind of B	usiness/Indu	ustry
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any	end Neme	19e. Informent's Name/R	eletlonship (7	ype, Print)		19b. M	ailing Address	Street	end Number or Rui	ral Route Numb	er, City or Town,	State, Zip C	Code)
	s 1 end 27 in Health them 27 in other tra	ELIZABETH	J. HIP	PCHEN (WIFE)				SMINE WAY	GAITH	ERSBURG,	MD. 2	0879
ore	of He	20a. Method of Disposition 1 ☐ Buriel 2 ☑ Cree		Removel from 5		Plece of Discemetery, of	sposition (Nemo cremetory or oth	e of ner plea	ce) T	Date DEC. 17,	20c. Location		
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ん Baltimore,	permit. Peges 1 Department of H Important: If He any Injury or ot phose.	21. Signeture of Funerel:	Service Licen	Day			22. Name and 10 EAS		es of Fecility DE EER PARK		NERAL HO		D. 20877
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Phn I Records	w requires that been signed to should be det	3 hyporten;	sien		-					24a. Wes	an autopsy ormed?	com	re autopsy findings ilable prior to apletion of cause eath?
D &	The law ate has b page 2 s	4 aremia,	neutro	ana ,	Eucher	enchiz	e" to cl	en	otherapy	10	Yes 2 No		Yes 2□ No
Vital	certificate rector, pag	25. Wes case referred to							26. Place of Deel				7.1
		axaminer? 1 ☐ Yes 2 ☐ No		Hospitel:	npatient 2	☐ ER/Outpa	tient 3 DO/	Oth	ner: 4 Nursing He	ome 5□Resi	dence 6 □Oth	er (Specify)	
Less ion of	Attending Physic death. crideath. by the funeral diffication: Te	27. Menner of Deelh 1 Neturel 5 2 Accident	Pending investigation		f Injury h, <i>Day Year)</i>	28b. Time Injur	e of 28	c. Injur Wor	y et rk? Yes 2 □ No	28d. Describe	how injury occur	red	
Pocher	or Attend sets death Director: / d in by the	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	289. PIECE	of Injury - At h g, etc. (Spec	home, ferm,	street, factory,	office			Street and Numi wn, Stete)	per or Rurel	Route Number,
H,	To the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:				sis of examin				ne, date end place, pinion, deeth occur				
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1000	State	31. Dete filed (Month, Da)	y. Year)	32. Re	gistrer's Sign	nature							

State Registrar

DHMH 16 Rev 6/95

DEC 21

32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** 4a Fecility Name (If not institution, 21,1999 December 6:10am /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth give street end number Examiner Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Dey, Year, January 23,1913 Sewickley, Pa. 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Months Deys Hours 1 M 2 N F 234-03-0555 86 Yrs. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural". or the many njury or other treumatic event 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Montgomery Director Brookville 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 210 Market Street 20833 USA Funerai 14. Race - American Indian. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Factory Worker Mantua Metal 12 17. Fether's Neme (First, Middle, Last) Herbert McGregor 18. Mother's Name (First, Middle, Meiden Surneme) Edna Miller 19a. informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William H.Wagner / Son 210 Market Street, Brookville,Md 20833 20b. Plece of Disposition (Neme of cemetery, cremetory or other p Date 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetlon 5 ☐ Other (Specify) Mantua Methodist Cemetery 12/24/99 Mantua, New Jersey 21. Signature of Funerel Service Licente 22. Name and Address of Fecility Philip D.Rinaldi Funeral Service 11818 New Hampshire Ave. Silver Spring, Md 20904 Approximete Intervel Between Onset end Death 23a Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock or hear feiture. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es a consequence of) Records, P.O. Box 68760. Physician/Medical thet initiated events resulting in deeth) Lest Due to (or as a consequenca of): 65 for use as 23b. Did tobacco use contribute to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. signed by t 2 No 3 Probably 4 Unknown 1 Yes þ 24b. Were eutopsy findings evailable prior to 24a. Wes en eutopsy performed? Completed peen completion of cause of deeth? this certificate has 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: director. 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 28e. Dete of Injury 28d. Describe how Injury occurred 28b. Time of 27. Menner of Deetl 28c. Injury et Work? Certification: 1 Neturel 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospital or Attenditional within 24 hours after death.
To the Funeral Director: A completely filled in by the fu Investigation 6 Could not be 3 Sulcide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated.

Medical Examiner: On the basis of examinetien and/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) and manner stated. Medical 29e. Certifier

29c. License number

of deeth (Item 23e) (Type, Print)

Registrer's Signeture

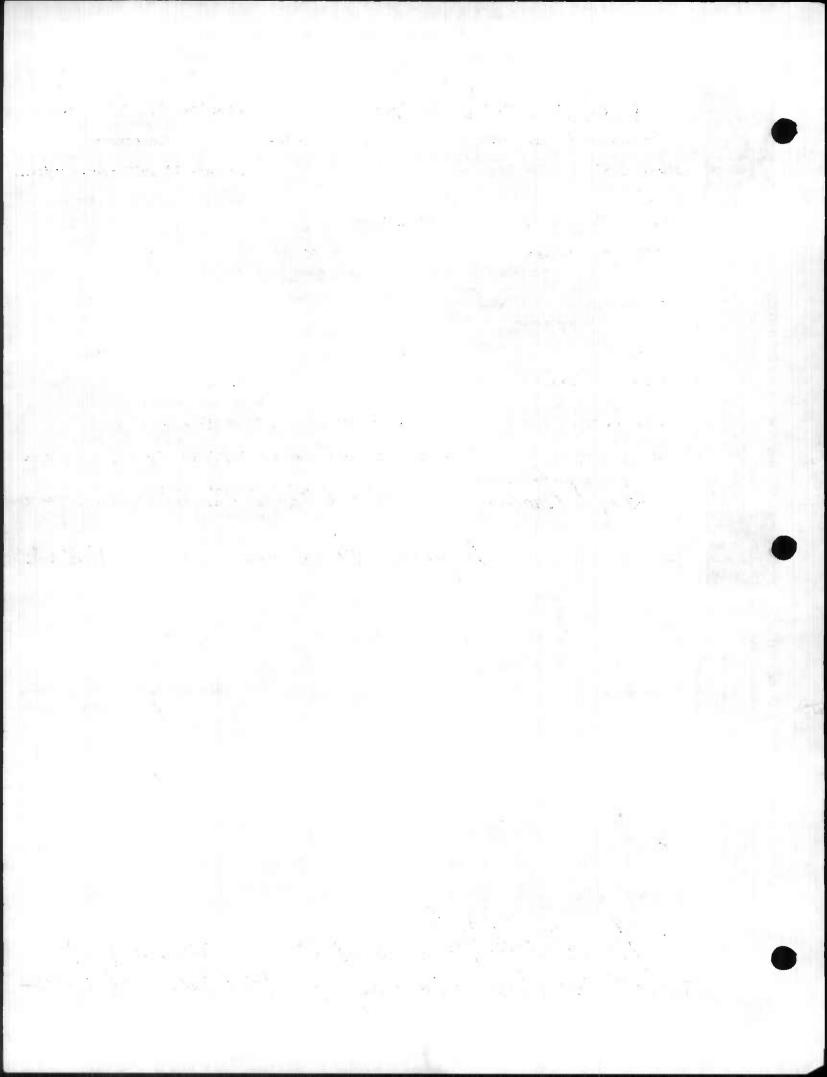
29d, Dete signed (Month, Day, Year)

State Registrar 29b. Signatoria

Trans Ex 31. Date filed (Month, Day, Year)

22

1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item #26, Per Phy. Certificate of Death 12/22/99, Carroll County, wj1 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** 1999 11:45 PM Dalma Ray Honeycutt Dec. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2409 Mayberry Road Westminster Carroll If Under 24 Hrs. If Under 1 Year 8. Data of Birth (Month, Day, Year, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Months Days Hours 15 M 2□ F 238-50-5661A Nov. 6 1933 North Carolina Director 66 Usual Rasidanca of Decedant 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits Maryland Carroll Westminster 1 Yas 2 XNo Director 288-1 9 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? na 23a or must be ò 21158 United States 2409 Mayberry Road Funeral **Name** Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forcas? 14. Race - American Indian, Black, Whita, atc. filed within 72 hours after I ☐ Yas 2 ☑ No If Yes, Giva 1 □ Navar Marriad 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: à White 3 Widowed 4 Divorced Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Carpenter Self-employed 10th 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit ment of Health and Mental H lant: if them 27 is marked off lary or other traumatic even Be Cleown Simmons Sim Honeycutt 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) New Windsor, MD 15119 Oak Orchid Road John Pfaff Friend 20a. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, crematory or other place) Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☒ Ramoval from Stata 12/22/99 Sunrise Cemetery Roseboro, North Carolina 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funaral Service Licens 22. Nama and Address of Facility Burrier-Queen Funeral Directors, P.A 1212 W. Old Liberty Road Winfield, dence? MD 21784 caused tha daath. Do not enter tha mode of dying, such as cardiac or respiratory arrest, aach lina. Entar tha disaasa, or complication **Physician** /Medical Immediata Causa (Final Adeno ardnor diseasa or condition resulting in death) Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Undarlying Cause (Disaase or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Bnd physician s the burial Box 68760. Physician/Medical Due to (or as a consequence of): esn 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed by the should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 certificate 1 Yes 1 ☐ Yas 2 ☐ No Division of Vital Physician: director. 25. Was casa ratarrad to medical 26. Place of Death (Check only one) 8 axaminar? 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Inpatiant - 3□ DOA this funeral 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Taxe of 28c. Injury at Work? After 1 Natural 2 Accident or Attending 5 Panding 1 Yes 2 No 24 hours after death. Funeral Director: A investigation 6 Could not be 3 Suicide 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) filled in by 4 ☐ Homicida Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the To the 29b. Signatura and titla of certifiar 29c. License number 29d. Date signed (Month, Day, Year) mounoshiga, mo 51705 20 30. Name and addrass of person who complated causa of death (Item 23a) (Type, Print) , westminster m. PANSURINA, MD 4195malle 31. Data filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 2 1999 Registrar

DEE 2 2 1859 James pl. Sporter

99-7812-017 CJ Robert Harry Hurd, Sr. Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 AMEND ITEMS: #23 PART I, 27 PER MEO Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** ROBERT HARRY HURD, SR. December 1999 07:15 AM. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner H Under 1 Yeer H Under 24 Hrs. 8. Date of Birth

Tanable Days Hours Min. Feb. 10, 1959 Civista Medical Center Charles 6. Sex 1XXM 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign *Funeral 218-76-1547 40 Yrs. Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. fnside City Limits or 28s-f show the Medical Examiner must be notified at the Many Yes 2 No Rock Island Silvis Illinois Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 1690 27th Avenue EM 61282 USA "natural", or items 23s Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 11. Merital Stetus 1 Yes 2 We
If Yes, Give
Year or Dates: Blad within 72 hours after 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: White Specify: p 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Owner/Operator Carpentry 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) should be in and Mental Marilyn J. Allen is marked Charlie M. Hurd, Sr. 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Retationship (Type, Pnnt) permit. Pages 1 and 2 sh Department of Health and Important: If them 27 is m any injury or other traum otics. Keri L. Hurd-Wife 1690 27th Ave., EM, Silvis, Ill 61282 20b. Place of Disposition (Name of cametery, cremetory or other place)
St. Joseph's Cemetery 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Surial 2 □ Cremetion 3 □ Removel from State 12-31-99 Pomfret, MD 4 ☐ Dongfilipn 5 ☐ Other (Specify) 21. Signature of Funetal Service Lifengee 22. Name and Address of Fecility
Huntt Funeral Home, Inc. MA Mark G. Brohawn M00053 P. O. Box 156, Waldorf, MD 20604-0156 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete intervel Between Onset and Death Physician /Medical Immediate Cause (Finel DILATED CARDIOMYOPATHY diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es a consequence of): The law requires that the death certificate be execut and Box 68760 Due to (or as a consequence of): the P.O. signed by the a Pert ff. Other afanificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Yes 2 No 1 Yes 2□ No Attending Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1X Yes 2□ No this 27. Menner of Death 28c. injury et Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by or A 4 Homicide To the Hospital
within 24 hours
To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end menner stated. Medical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. December 28, 1999 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 JACK MITIMS. miD 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State JAN 0 3 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene 9 9

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	10) 10	/	30, Nama and address of person who o	complated causa of death (Its	am 23a) (1	Type, Print).	n	, , , ,		1		20)	1111
(7 19	9	Patricia L. Toms,	ko, MD, 11140	Roc	kville	Pik	E, PMB	348, Ro	ckville	, mi	208	52
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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12 **Physician** 1999 HAWKINS 18 LINKFIELD 8:00 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner PRINCE GEORGE'S SPRINGDALE 3605 SETH COURT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 7, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours North Carolina 718-10-8076 1 M M 2□ F 1901 98 Yrs May Director Usual Residence of Decedent the Maryland 10e Stete 10b. County 10c. City. Town or Location 10d Inside City Limits 1 N Yes 2 No Maryland Prince George's Springdale Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ď 20774 U.S.A. must be 3605 Seth Court Berns 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Bleck White etc 72 hours after 1 ☐ Yes 2 X No 1 ☐ Never Merried 2 ☐ Merried *natural", or I Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify Black þ 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6th Bridge Engineer Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event Be Linkfield Hawkins Martha Pippiquin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3605 Seth Court, Springdale, Maryland 20774 Lois M. Martin/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/27 1 ☐ Buriel 2 ☐ Cremetion 3 X Removel from State Greenwood Cemetery New Bern, North Carolina 4 □ Donetion 5 □ Other (Specify) 1999 21. Signeture of Funerel Service Licensee J. B. JENKINS FUNERAL HOME No 7474 Landover Road, Landover, Maryland 20785 23e. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel A CARDIORESPIRATORY FAILURE minutes disease or condition resulting in death) Examiner Due to (or es a consequence of) Examiner ARTERIOSCIEROSIS (GENERAL) ician and burial-transit the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial Box 68760 Physician/Medical Due to (or es a consequence of) 80 950 ò 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert t. signed by t 1 Yes 2 No 3 Probably 4 Unknown GOUT ARTHRITIS Records, þ The law requires 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed pege 2 s 1 Yes 2X No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director. 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? After 5 Pending n 24 hours after deeth.

The Funeral Director: After the further t 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, Stete) 28e. Plece of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mayiner stated. 29a. Certifier edicai completely (Check only To the To the To the 29b. Signature end title of certifie 29c. License numbe 29d. Dete signed (Month, Day, Year) 30 Name and address of person od cause of death (Item 23a) (Type, Print) 10 4922 Beech Road, Temple Hills, Maryland TON

DHMH 16 Rev 6/95

State Registrar

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1. Date filed (Month, Day,

32. Registrar's Signeture

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Piease Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month **Physician** Daniel H. Herbert Dec 12,1999 2120 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Months 1 M 2 F 579-38-9576 94 Director 1/15/05 WASHINGTON, DC Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County DC N/A WASHINGTON TY Yes 2 No Director 28a-f 96 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mast be n 1935 QUINCY STREET NE 20018 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 Thio If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Meritei Status Bleck, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 8 1 Yes 200 Specify: Specify: BLACK þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 12 YEARS College (1-4or 5+)
4 YEARS DC PUBLIC SCHOOLS TEACHER 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be fill ment of Health and Mental Hant: If Item 27 is marked oth lury or other traumatic even Be JAMES HERBERT MAMIE GREENE 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 8302 BETTY H. HILL (DAUGHTER) 3433 FRANKLIN ROAD, BLOOMFIELD HILLS, MICHIGAN 20b. Place of Disposition (Name of 20a. Method of Disposition 20b. Place of Disposition (rearrie or camelary, crematory of other place)
LINCOLN MEMORIAL CEMETERY
12/17/99 20c. Location - City or Town, Stete 1 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) SUITLAND, MD. 15 21. Signature of Funeret Service Liceni 22. Name end Address of Fecility JOHN T. RHINES CO., INC. CC0273. 3030 12TH ST NE, DC 20017 Ant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last and Box 68760, Be Completed by Physician/Medical the Due to (or es a consequence of): for use Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably Toldinknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? certificate 1 Yes 1 Yes 2 No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 R/Outpatient 3 DOA 1 Inpatient this funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? aturel 5 Pending investigation 2 Accident 1 TYes 2 No death. To the Hospital or Attend within 24 hours after deatl To the Funeral Director: 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homtcide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29e. Certifier (Check only 29b. Signature and title certifier 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar John Marg lis MD

DEC 2 0 1999

31. Dete filed (Month, Day, Year)

DHMH 16 Rev 6/95

32, Registrar's Signature

13952 Baltimore Ave. Laurel Md 20707

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	Decedent's Name (First	st, Middle, Las	1)						2. Dale of D			Van	3. Tima	of Death
an V	ictor All	len Ha	11						Month DECEM		ay 19.1	Year 999	2:10	P.M.
	Facility Name (If not in	institution, give	street and numb	per)			4b	. City, Town, o	r Location of Dea		c. County	of Death		
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	Social Security Number	15	x 7. ⊋M 2□F	Age (In yrs.	last birthday Yrs.	y) If Under Months	1 Yeer Days	If Under 24 H	n. (Month, E				lace (Stete try)	or Foreign
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State Registrar

DEC 2 8 1999

2. Registrar's Signature

from the street

Bee: 8 2 936

Please Type or Print in Black Indeiible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Dec **Physician** 10:15 pm /Medical 4e Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner HOWARD COUNTY GENERAL HOSPITAL HOWARD COLUMBIA MD. If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foraign Country) **Funeral** Days Months Hours 1♥M 2□F Director VIRGINIA 231-48-4675 59 Aug. 2, 1940 Usual Rasidance of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or hems 23s or 28s-f ahov the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo NORTHUMBERLAND REEDVILLE VIRGINIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mentel Hygiene.

Int: If Item 27 is marked other than "natural", or frame 23a or inty or other traumatic svent, the Medical Examinar must be a 496 Black Berry U.S.A.22539 Road Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indien. 11. Marital Status Black, White, atc. 1 ☐ Nevar Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify Š 3 ☐ Widowed 4 ☐ Divorced Afro American Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elemantery/Secondary (0-12) College (1-4or 5+) FISHING/CRABBING 6 WATER MAN 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be CARLTON STEWART HARCUM ETHEL BENNS HARCUM 19e. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Black Berry 1 94 REEDVILLE Road F VIRGINIA 22539 496 MARGARET HARCUM O. BOX 20a. Method of Disposition 20b. Ptece of Disposition (Name of cematary, crematory or other place) Date 20c. Location - City or Town, State 1 Buriel 2 □ Cramation 3 □ Ramoval from Stata permit. Page Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) Shiloh Baptist Church | 12/18 | Burgess VA. 22432 22. Name and Address of Facility Berry O. Waddy 21. Signature of Funaral Service Licenses P.O.Box 305 6784 Mary Ball Road Lancaster VA.22503 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart letiture. List only one cause on each life. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disaasa or condition resulting to death) Examiner (or es a consequence of) Examiner The law requires that the death certificate be executed the burial-trensit Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Couse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of) Box 68760 Completed by Physician/Medical Dua to (or es a consequence of): 950 P.O. Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? page 2 should be detached 3 Probably 4 Unknown 1 Yes 2 No Records, 24b. Wara autopsy lindings evallable prior to completion of cause of death? 24a. Wes an eutopsy performed? 2 No certificate 1 ☐ Yes 1 Yes 2□ No of Vital or Attending Physician: 25. Wes case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Sthpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) funeral 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After Division 5 Pending investigation 1 Netural 1 Yes 2 No 24 hours after death. Funeral Director: A the 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicida filled in Hospital 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date end place, end due to the cause(s) end mennar es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. Medicai 29e. Cartifiar completely (Check only one) within 2. To the F \$ 29b. Signature end little of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Neme and add eted causa of death (Item 23a) (Type, Print) MONTH DAVE COLUMBIA MD 21045 IMD restruct TWOKNOL 31. Dete filed (Month, Dey, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

DEC 2 2 1999

Sandy & Sandy Spirit and the

Physician /Medical Examiner bunial-transit P.O. Box 68760. the

Physician

/Medical

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Funeral

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filed within 72 hours after

Pages 1 and 2 should be f nent of Health and Mental I nt: If item 27 Is merked of 7 is marked of traumatic ev

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permit. Page Department of Important: If eny Injury or once. = 8

21215-0020

Baltimore, Maryland

Be

Examiner Physician/Medical þ Completed Certification: To

igned by the ette certificate Hospital or Attending Physician: 24 hours efter death.
Funeral Director: After this certifica stell filled in by the funeral director; • Funerel Medica

Records,

Division of Vital

To the within 2

State Registrar

GLOBAL COGNITIVE DYSFUNCTION MULTIINFARCT DEMENTIA 25. Wes case referred to medical exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpetlent 3 DOA Magner of Deeth 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigetion 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 29a Certifie 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 295. Signature and title of certifier 29c. License number

neune

29d. Dete signed (Month, Dev. Year)

A60847 CA

DECEMBER 20, 1999

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

89 MDG/1050 W PERIMETER RD

PEERACH P. PHERMSANGNGAM, CAPT, USAF, MC

ANDREWS AIR FORCE BASE, MD 20762-6600

31. Dete filed (Month, Dey, Year)

DEC 2 2 1999



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Please Type or Print in Black Indelible ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Month Dav **Physician** 21, 1995 ath 4c. County of Death Erika 11:10 AM Hickey Dec. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4305 Rockport Lane 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** 1 M 2 F 214-76-9287 Director 60 Usual Residence of Decedent 10e State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1□ Yes 2□ No Director 28s-f Md. Prince Georges Mitchellville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 4305 Rockport Lane 20720 Funeral Germany 14. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritai Status 72 hours after if Hygiens, other than "natural", or its event, the Medical Examin 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within Elemantary/Secondary (0-12) College (1-4or 5+) Bank Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is manked other Any Injury or other traumetic event Be Johann Kinderman Elsa Spieler 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Thomas Hickey - Son 6308 Shipley Court, Hanover, Md. 21076 1 2 Dales _ 9 920c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lakemont Mem. Gardens Davidsonville, Md. 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Shannon W. Beall Beall Funeral Home 6512 N.W. Crain Hwy., Bowie, Md. M00798 20715 23a. Part 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) · CEREBRAL ELASTATIC CANCEL Month Examiner Due to (or as a consequence of) Examiner rear LUNG CANCER ician and buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events rasulting in daath) Last Due to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequenca of): Part It. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown EMPHYSEMA by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Aesidence 6 Other (Specify) this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? After 5 Pending investigation 1 Yes 2 No 24 hours after deeth.

Funeral Director: A 2 Accident 3 Suicide 6 Could not be datarminad 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifiar edicai completely (Check only one) within 2 To the F \$ 29b. Signature and title of cartifier 29c. License number 29d. Data signed (Month, Day, Year) D 31069 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
GEORGE, H. BONE H.D 1100 MERCANTILE LN #135 LARGO MD 20774 31. Date filed (Month, Day, Year) 32 Registrar's Signature State **DEC 2 2 1999** Registrar

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECMEBER 20, 1999 EARL MELVIN HUNLEY 4:50pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Nov. 18, 1933 6. Sex ... 1 M 2 F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 578-14-2034 66 Washington, D.C. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f ahow 1XXYes 2□ No Md. Director Montgomery Takoma Park 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code death with "naturel", or items 23s or 7620 Maple Ave. #402 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 11 Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or han eny injury or other traumatic avent, the Medical Fairm name Black, White, etc. 1♥ Never Married 2 Married Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: 20 3 ☐ Widowed 4 ☐ Divorced Black. Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GOODWILL INDUSTRIES CHARITY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 JOHN HENRY HUNLEY JUANITA EUDORA 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) EUDORA CLAYTON/DAUGHTER 7016 Palamar Terrace, Lanham, Md. 20706-2151 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hills Memorial Gar. 12.29 99 Clinton Md
22. Name and Address of Facility Butler & Sons Inc. 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility 716 Kennedy St., N.W. Wash.D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the burief-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 95 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Moidos.S algned b Records. à Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy parformed? Completed capetes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

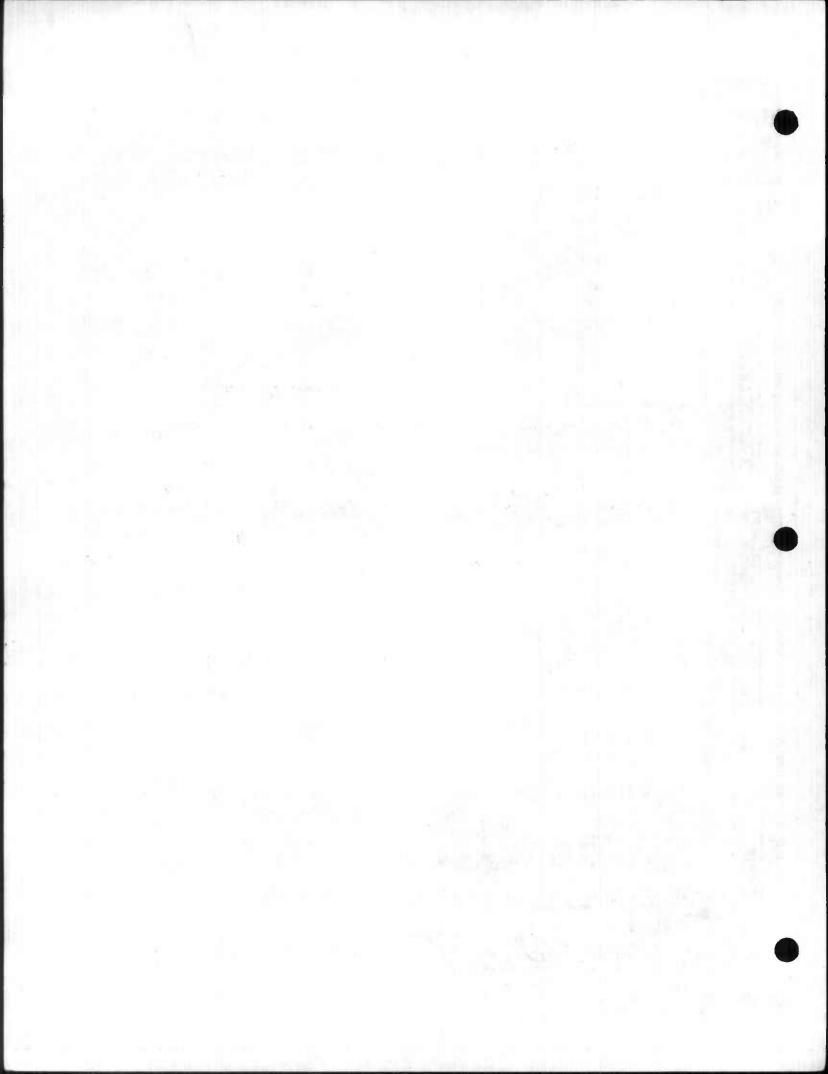
To the Funeral Director: After this cartifical completely filled in by the funeral director; I 25. Was case referred to medical examiner? 89 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 29c. License number eath (Item 23a) (Type, Print) 30. Name and address of person who come 04 31. Date filed (Month, Day, 32 Registrar's Signature DEC 2 3 1999 Registrar

DEC 2 3 1999 Summer . S. Strand

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth **Physician** 18, 1999 Wilbur Wayne Jackson December 4:45 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Mo. | Hours Min. | Month, Day, Year) Holy Cross Hospital Montgomery If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days IN ALLE Yrs. Director 236-26-6224 78 Nov 21, 1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Wedical Examiner must be notified at 1 ☐ Yes 2 ☐ No Maryland | Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 늄 WITH deeth y 14357 Rosetree Court 20906 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status flied within 72 hours efter 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be flied v Department of Heelth and Mentel Hygier Important: if Item 27 is marked other then any Injury or other treumatic event, the page. 4 Engineer Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 2 Samuel E. Jackson Anna B. Kronk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary D. Jackson/ Wife 14357 Rosetree Court, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/21/99 Silver Spring, MD Gate of Heaven Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 at caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, on each line. 23a. Part / Enter the disease, or comp shook, or heart failure. List only Approximete Intervel Between Onset end Death **Physician** Immediate Cause (Finet disease or condition resulting in death) /Medical a Colon cancer 1 month Examiner Due to (or as a consequence of): Examiner physicien end s the burlei-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as e consequence of): 3 for use as 987 deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings eveilable prior to 24a. Wes an autopsy performed? been a Completed completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital certifica director. 8 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After this funerel 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fune or Attending 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 29a. Certifier Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. (Check only one) miner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and dua to the cause(s) and manner steted. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D34032 12/20/99 and address of person who completed cause of death (Item 23a) (Type, Print) 3720 20895 Farragut Ave., Kensington, MD eanne P. Asher Date files (Month, Day, Year) 32. Registrar's Signature State **DEC 21** Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death **Physician** CLARENCE W. JOHNSON 13, DEC. 1999 7:20 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (Il not Institution, giva street and number) 4c. County of Death Examiner Casey House, 6601 Muncaster Mill Rd Rockville MONTGOMERY If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year, If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foraign Country) Maryland 6. Sex **Funeral** Months Days 10 M 2 □ F 218-05-2262 95 Jan.8, 1904 Director Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County rai', or items 23a or 28a-f ahow Examiner must be notified at 10d. Insida City Limits Montgomery Rockville 1X Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 N. Van Bruen Street 20850 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian. 11. Maritel Status filed within 72 hours effer thygiene. Armed Forces? 1 Yes 2 No 1 Never Married 2 Married Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Giva kind of work done during most of working lifa. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5th Mechanic Auto Co. other permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: If flem 27 is marked othe any injury or other traumatic event page. 17. Father's Neme (First Middle Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) Be Jacob Johnson Idella McDonald 19a. Informant's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 20850 Albert Sewell (Nephew) 605 N. Stonestreet Ave., Rockville, MD 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata ₩ Burial 2 Cremation 3 Removal from State Parklawn Mem. Park 12/21/99 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funerel Service License llo mallu ROCKVILLE, MD 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haar failure. List only one cause on each line. Approximata Interval Batween Onsat end Death **Physician** /Medical Immediale Cause (Final diseasa or condition rasulting in death) Examiner Physician/Medical Examiner physician end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Y88 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 200 No 1 Tas 1 🗆 Yas 2 1 No 25. Was case referred to medical B 26. Place of Deeth (Check only ona) axaminar? To Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) HOSPICE 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred edical Certification: 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide

of Vital this Division Affer or Attending death. ours after death eral Director: / filled in by the f To the Hospital within 24 hours a To the Funeral Completely filled Hospital

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Box

P.O.

Records.

the Maryland

Baitlmore, Maryland 21215-0020

State Registrar

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

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DHMH 16 Rev 6/95

and manner steted.

32. Re

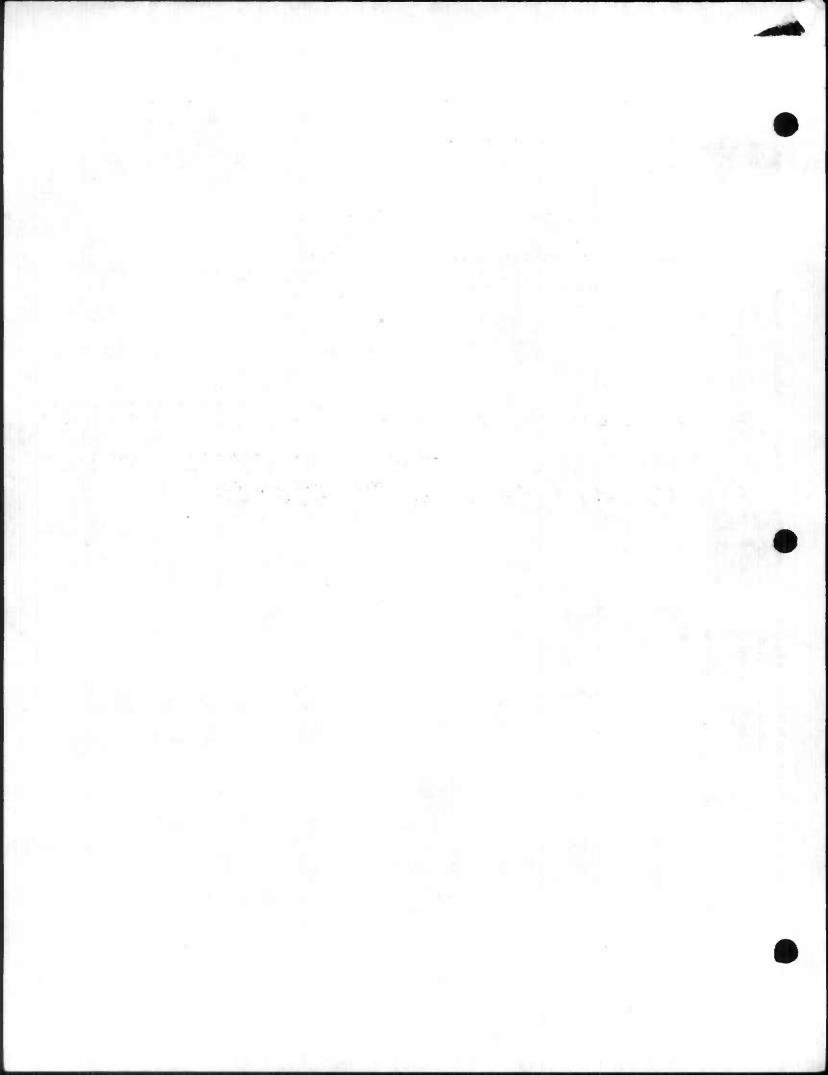
gistrar's Signature

13 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s)

29c. License number

P.Ke PMB348,

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death North BER 17 1999 EROME JAMES JACKSON 3:40 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANHAM, M.D. P.

If Under 24 Hrs. 8. Data of Birth
Hours Min. 3/25 991/2 DOCTOR'S HOSPITAL 7. Age (In yrs. last birthday) Yrs. If Under 1 Year | If Under 24 Hrs. | Months Days | Hours | Min. | 5. Social Security Number 577-16-3482 10 M 20 F Months WASH. 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside, City Limits LANHAM 1 Yas 2□No D 10f Zip Code 10g. Citizen of What Country? U.S. F 20706 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yes, Giva Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, Whita, etc. BLACK 1 Never Married Married 1 Yas 2 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Giva kind of work dona during most of working
lifa. DO NOT use retired)

BINDER 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. GOV'T, ntary/Secondary (0-12) College (1-4or 5+) 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middle, Last) EDWARD JACKSON UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zio Code) WIFE 5516-BELVA PLI, LANHAM, MD, 20706 ACKSON, 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, State 20a. Methed of Disposition 1 1 Burial 2 □ Cremation 3 □ Removal from Stata LANDOVER, MD. HARMONY MEM. 4 □ Donation 5 □ Other (Specify)

21. Signature of Futural Service Licensee 22. Nama and Addrass of Facility
22. Nama and Addrass of Facility
450 WS, INC., Co.,
450 WS, UNSHINGTON 450 WS, INC., Co.,
4925-N.H. BURROUGHS AVE., N.E., WASH., D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediata Causa (Final disease or condition rasulting in death) DAMS BROWN 300 OF MWON 17 Due to (or as a consequence Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CEREBRAN 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? PACEMARKER 200 No 1 Yas 2 No 25. Was case refarred to medicat axaminer?
1 ☐ Yas 2 ☑ No 26. Place of Death (Check only one) Hospital: 1 httpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending investigation 1 ☐ Yas 2 ☐ No 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Physician /Medical Examiner Box 68760 P.O. Records, of Vital Division

Physician/Medical Examiner physician at the burial þ Completed Certification: To Be this

Physician

/Medical

Examiner

Director

þ

Funeral

Director

b

s 1 and 2 should be filed w f Health and Mental Hygle flem 27 is marked other ti

Important: If Item 27 Is any injury or other tra once.

ROME

ne Hospital or Attending Pt n 24 hours after death. Ne Funeral Director: After the pletaly filled in by the funera To the Hosp within 24 hor To the Fune completely fi

Medical

Registrar

3 ☐ Suicide 6 Could not be 4 Homicide

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28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marinar as stated. 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. Licanse number D1619

29d. Data signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) MO-0336 LANKEM-SOIGH RO. BHASIM, MY

31. Data filed (Month, Day, Year)

DEC 2 2 1999

29a. Certifier

(Check only one)

29b. Signature and title of certifie

32. Registrar's Signatura

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Nama (First, Middla, Last) 2. Dete of Deeth 3. Time of Death Yae Month 12 **Physician** Clarence William Jeffries, 16 199 11:53 AM /Medical 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MARYLAND HEALTH CARE SYSTEM FORT HOWARD PALTIMORE Hours Min. 8. Data of Birth (Month Day, If Under 1 Year 5. Social Security Number 7. Age (In yrs-last birthday) 9. Birthpiace (Stata or Foreign **Funeral** Deys Virginia Months 1 ☑ M 2 □ F Yrs. Director 229-13-5382 76 Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits reast be notified at Y Yes 2 No Director MD N/A Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t 1300 N. Bentalou St 21216 Funeral United States death 12. Was Decedent Evar in U,S. Armed Forcas? 1∑ Yes 2 □ No If Yas, Give Yeer or Dates: 1941–1945 Rema Was Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amaricen Indian, Black, Whita, etc. 11 Meritel Status filed within 72 hours after 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 6 1 Yes 2 No Specify: Specify: Black à 3 X Widowed 4 ☐ Divorced Completed Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry than Elamentery/Secondary (0-12) Collega (1-4or 5+) Hat Blocker Millinary 10 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event Be Clarence Jeffries, Sr Helen Lindsay 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Augusta E. Williams/Personal Rep 1300 N. Bentalou St. Baltimore, MD 21216 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Chesapeake Crematory Inc 12-20-99 Beltsville, MD 4 ☐ Donation 5 ☐ Othar (Specify) Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Facility CAFA Stephen D. Lorhmann, P.A. 8717 Green Pastures Dr., Baltimore, MD 21286 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Deeth **Physician** /Medical Immediata Cause (Finel gastrointestinal bleeding hours diseasa or condition rasulting in deeth) Examiner Due to (or as e consequance of) Examiner esophageal cancer 7mont 1 year The law requires that the death certificate be executed and Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Causa (Disaase or Injury that Initiated avants rasulting in deeth) Last Dua to (or as a consequence of): Box 68760, Physician/Medical the Dua to (or as e consequance of) USB BS Part II. Other algorificant conditions contributing to death but not rasulting in the underlying ceuse given in Part I. 23b. Dtd tobacco use contribute to the cause of death? P.0. ed by 3 Probably 4 Unknown 1 Yss 2 No OBSTRUCTIVE PULMONARY DISEASE CHRONIC Records, P should be 24b. Ware autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy ADENOMA OF COLON TUBULAR page 2 1 DYas 2 No 1 □ Yes 2 □ No After this certificate Division of Vital or Attending Physician: funeral director, 25. Was casa rafarred to medicel 26. Place of Death (Check only ona) axaminar? Hospitel: 1 Inpatiant Othar: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) edicai Certification: To 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 ONatural 5 Pending 1 ☐ Yas 2 ☐ No death. investigation 2 Accident To the Hospital or Attention within 24 hours after deatl To the Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Plece of Injury - At homa, farm, street, factory, office building, alc. (Specify) pletely filled in by 4 Homlcide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end mennar es stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and place, and due to the cause(s) and mannar stated. 29a. Cartifiar (Check only one) 29b. Signetura and titla of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) U ano True wtokuso 30. Name and address of person who complated ceusa of death (Itam 23a) (Type, Print)

Registrar

State

31. Data filed (Month, Day, Year)
32. Registrer's Signeture
DEC 2 1 1999

CUSTODIO MD.

B. frak

POINT ROAD" FORT

HOWARD , md. 21052

NORTH

9600

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** December 15, 1999 Herman T. Jones 11:30am /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 24 Hrs. Hours | Min. 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) 9. Birthplace (Stete or Foreign **Funeral** Days Months 1₺ M 2□ F 82 Yrs. 577-22-5736 Director Sept. 11, 1917 Caswell, N.C. Usuel Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at ty Yes 2 □ No Maryland | Montgomery Funeral Director Silver Spring 10e. Street and Number Rd. 10f. Zip Code 10g. Citizen of What Country? with 6 1220 Blair Mill Apt. #200 20910 Herns 23a United States death 12. Wes Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus filed within 72 hours after 12 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 6 21215-0020 1 Yes 2 No Specify Specify: Black þ 3 Widowed 4 □ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementery/Secondery (0-12) College (1-4or 5+) Postal Clerk U. S. Government Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Pages 1 and 2 should be fit ment of Health and Mental Hant: If them 27 is marked other traumatic even ury or other traumatic even Henry Jones Mamie Lea 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald Bigelow / Nephew 9008 Cooper Dr. Ft. Washington, Md. Baltimore, 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Department of Important: If any Injury or once. Chesapeake Crematory 12/17/99 Beltsville, md. 4 □ Donetion 5 □ Other (Specify) Alexander S. Pope Funeral Homes 21. Signature of Funerel Service Licensee 5538 Marlboro Pike/Forestville, 23a. Perti. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Md. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in deeth) Examiner Examiner Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last pue Due to (or as a sensequence of): Box 68760. physician ANCER Physician/Medical eun Due to (or es a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Division of Vital Records, Completed 24a. Was an eutopsy performed? 24b. Were eutopsy findings available prior to 1 ☐ Yes 2 1 No this certificate 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Naturel 1 Yes 2 No To the Hospital or Attendition 24 hours after death.

To the Funeral Director: A death. 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 29e. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated. edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature aparties of certifier 29c. License number 29d. Date signed (Month, Day, Year) 809/80445 12.15.1989 Woodynd Rd. Suit FF 50 1 CLING. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

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32, Registrer's Signature

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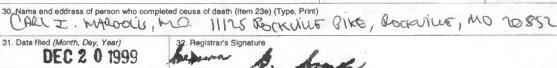
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedant's Nama (First, Middle, Last) Month JULIUS. KRAUSE IH **Physician** 0836 H /Medical 4e Fecility Name (If not Institution, give street end number)
WASHINGTON ADVENTIST HOSPITM 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** TAXOMA PALK MONTEOMENY 8. Date of Birth (Month, Day, Yeer) If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** 1 M 2□ F Months Deys Hours 579-42-8919 Yrs. 63 July 1, 1936 Washington, DC **Director** Usuel Rasidence of Decedant with the Marylend r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Maryland Montgomery Takoma Park Directo 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours eftar death with I Department of Health end Mental Hygiena.
Important: if item 27 is merked other than "natural", or items 23a or any injury or other treumetic event, the Medical Example mail be in once. 7500 Hancock Avenue 20912 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Meritel Stetus 1 X Yas 2 No If Yes, Give 2/8/54 Yeer or Dates: 6/12/5 1 ☐ Navar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 6/12/57
16e. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Collega (1-4or 5+) Elamentary/Secondary (0-12) Carpenter Home Improvement 18. Mothar's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Julius Herman Krause II Frances Rose Schoenlieber 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy Krause - Wife 7500 Hancock Avenue, Takoma Park, MD 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crametory or other place) 20c. Location - City or Town, State 1 N Buriel 2 ☐ Cremation 3 ☐ Removal from State 12/23/99 4 ☐ Donetlon 5 ☐ Other (Specify) Arlington National Cemetery Arlington, Virginia 22. Name and Address of Fecility
Gasch's Funeral Home, P.A. 21. Signeture of Funerei Service Licensee 4739 Baltimore Avenue, Hyattsville, 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximeta Intarval Batween Onset and Death Physician AMERIDECUEROTIC CARDIDUASCULAR DISONSE Immediate Ceuse (Final disease or condition rasulting in death) /Medicai Examiner Due to (or es a consaguança of) Examiner physician and s the buriel-transit requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediata ceuse. Enter Undarlying Cause (Disease or Injury that Initiated events resulting in deeth) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 98 950 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed certificate has 20110 or Attending Physician; 25. Was casa raferred to madicel agaminer? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 2 10 Ves 2□ No 1 Inpatient 2 ER/Outpetient 3 DOA this 28a. Date of injury (Month, Day Year) funaral 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. Injury at Work? Certification: Aftar 1 Naturel 5 Pending s aftar death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datarmined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 3 Suicide Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital 24 hours edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, end due to tha ceuse(s) end menner as stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end manner steted. within 2 the 29c. License number (0M*)

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DECOMBER 17, 1999

Registrar

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		Certificate of Death	Reg. No. 99	41828							
Dhuninina	Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death							
Physician /Medical	Frances T. Kidd	I	Month Day Year December 20 199	9 11:25AM							
Examiner	4a Facility Name (II not institution, give street end number)	4b. City, Town, or Loc	ation of Death 4c. County of Dec	eth							
	5111 Hesperus Drive	Columbia		d							
Funeral Director	201-40-3010	7/3.		nthplace (State or Foreign ountry)							
p .	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Towr	or Lecetion		10d. Inside City Limits							
with the Meryland a or 28a-1 ahow Lea notified at			1 DYYes 2 No								
28a-1	Maryland Howard 10e. Street and Number	Columbia	10-07	**							
23a or rai Dir	5111 Hesperus Drive	10f. Zip Code 21044	United S	10g. Chizen of What Country? United States							
hydiene. her than "natural", or flema 23a or 28a-fa nt, the Medical Examiner main be noutlied Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Detes:	13. Wes Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R 1 ☐ Yes 2 ☐ No Specify:	ify Yes or No- ican, etc.) 14. Race - Am Black, Whi Specify: B]	ite, etc.							
'natural', deal Er	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working	16b. Kind of Business								
npie	Elementery/Secondary (0-12) Cottege (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)		Citizens							
al Hygiene. I other than " went, the May Be Comple	The state of the s	Director	Program								
merked out	17. Father's Name (First, Middle, Last) Unknown	18. Mother's Name	(First, Middle, Maiden Surname) Unknown								
pue el	19a. Informent's Neme/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Rural	Route Number, City or Town, State,	Zip Code)							
item 27 l	Marva Kidd - Daughter	5111 Hesperus Dr., Co.	lumbia, MD 21044	+							
Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Monce. To Be Comp	20a. Method of Disposition 1 Burlal 2 Cremation 3 Removal from State 20b. Place of cemeter cemeter Let	Disposition (Name of y, crematory or other place) e's Crematory 12.	Date 20c. Location - City of Clint	Town, State							
Department of Important: If any Injury or once.	21. Signature of Funerel Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20										
	23a. Part 7. Enter the disease, or complications that caused the death. Do n shook, or heart failure. List only one cause on each line.			. 20019							
Medical xaminer xaminer Examiner	Immediate Cause (Final disease or condition resulting in death) a. Lanculation Due to (or as a company)	consequence of):		my month							
as the bu	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of):										
the attendin thed for use ysician/N				1							
detac	Part II. Other algnificant conditions contributing to death but not resulting in	the underlying cause given in Part I.	\	Did tobacco use contribute to the cause of death? 1 Yes 2 Aho 3 Probably 4 Unknown							
page 2 should be de completed by F			24a. Wes an autopsy performed?	Were eutopsy findings available prior to completion of cause of death?							
is certificate has to a director, page 2 s. To Be Comple			1□ Yes 2 No	1□ Yes 2DINo							
or, p	25. Wes case referred to medicat	26. Place of Death									
his certifi Il director To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Out	Other	e 5 Residence 6 □Other (Sp.	aciful							
h. After this funeral di	27. Manner of Deeth 28a. Date of Injury 28b. T		3d. Describe how injury occurred	ecny)							
24 hours after deeth. Funeral Director: After to the filled in by the funeral lical Certification:	3 Sulcide 4 Homicide Could not be determined (V 1) 28e. Place of Injury - At home, fer building, etc. (Specify)		Bf. Location (Street and Number or F City or Town, State)	Rural Route Number,							
A hour Funer tely fill	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one)										
within 2 To the comple	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	oth, Day, Year)							
	1 monthstation D 0052450 12/21/99										
(3)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 141 Security Blue	Baltimore A	1021244							
State Registrar	31. Date filed (Month, Day, Year) DEC 2 2 1999 32. Registrar's Signature	. dans									

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedant's Name (First, Middle, Last) 2. Data of Death Day Month Year **Physician** Ruth W. Laird December 20, 1999 10:00 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Kensington Park Assisted Living Kensington
If Under 24 Hrs. 8. Data Montgomery If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2 F Months Hours Director 179-30-1777 July 22, 1906 Delaware 93 Usual Rasidence of Decedant the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or heme 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 🕅 No Director Maryland Montgomery Kensington 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 3618 Littledale Road 20895 United States death Funeral 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours elter inent of Heelih and Mental hygiene.

Intel I flem 27 Ie marked other than "natural", or he iny or other traumatic event, the Marian En min 1 ☐ Yas 2 💆 No If Yas, Giva 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify ò 3 Widowed 4 □ Divorced Yaar or Datas: White Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Public Schools 4 Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) B Victor Washburn Mae Louise Doane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 841 Oak Road P.O. Box 159 19a. Informant's Name/Relationship (Type, Print) Winthrop W. Laird/ Son Bradfordwoods, Pennsylvania 15015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State December 1 ☐ Buriai 2 ☐ Cramation 3 ☐ Removal from State permit. Page Department of Important: If eny Injury or page. 4 ☐ Donetion 5 ☐ Othar (Specify) Montgomery Crematorium Inc. 22, 1999 21. Signature of Funeral Sarvice Licensee

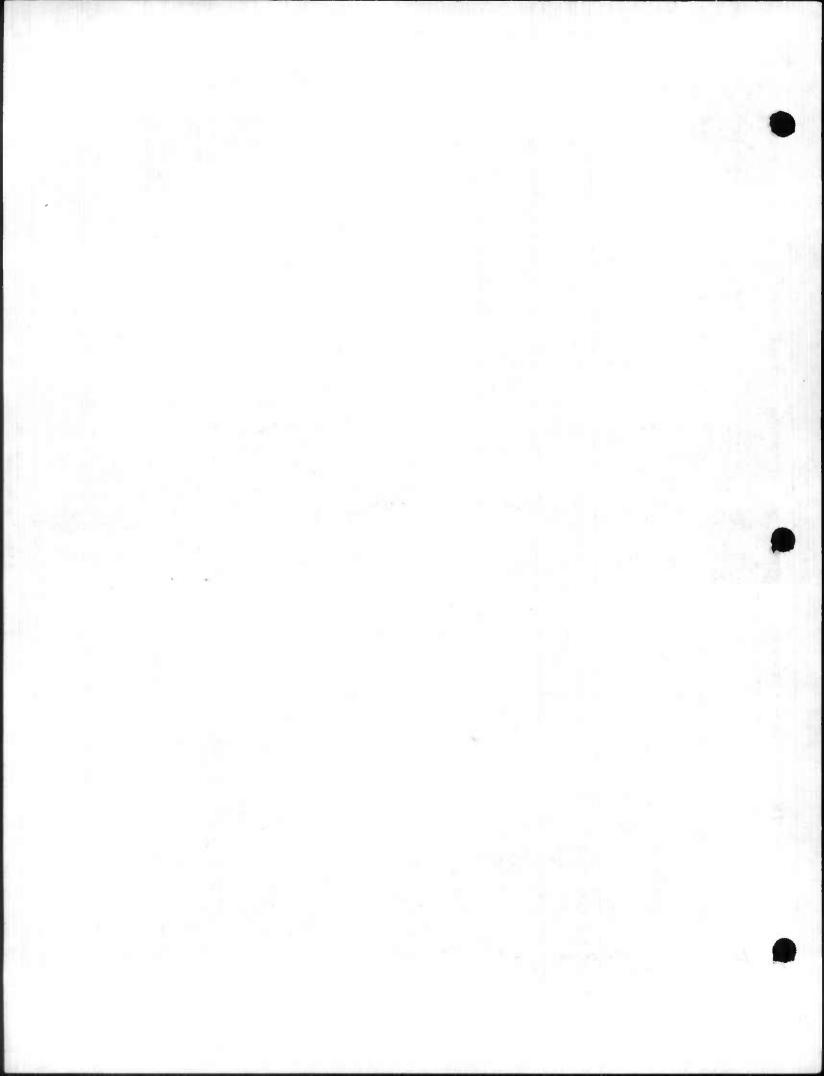
22. Nama and Address of Facility
Robert A. Pumphrey Funeral Home
Rockville, Inc. 300 West Montgomery Avenue

23a. Part. Enter the effsease, or samplications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest,
Approximately of Emidel of Lucinity Bethesda, Maryl Bethesda, Maryland Approximeta Intarval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in deeth) Myocardial Infarction Immediate Examiner Dua to (or as a consequence of) Examine ician and burial-transit The law requires that the deeth certificate be executed Sequantially list conditions, if any, leeding to immadiata cause. Enter Undarlying Cause (Disaase or injury that initiated evants resulting in daath) Last Dua to (or as a consequence of): physician s the buria Box 68760. Physician/Medical Dua to (or as a consequence of): signed by the at d be deteched for P.O. Part II. Other algnificant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Carcinoma Breast Division of Vital Records. þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 2 No 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was case rafarred to medical axaminar? Be 28. Place of Death (Check only one) Assisted Hospital: Other: 4 Nursing Home 5 Residence 6 KOther (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Living funerel 27. Mannar of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Affar 1 Natural 5 Pending ne Hospital or Attending in 24 hours after death. The Funeral Director: Aft reletaly lifted in by the fur 1 ☐ Yes 2 ☐ No invastigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28a. Pleca of tnjury - At home, ferm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and dua to the cause(s) and mannar as stated To the Hosp within 24 hos To the Fune completaly li (Check only one) 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred et the time, date end piece, and due to the cause(s) and manner stated. 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) ewer D_05256 December 20, 1999 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) 6000 Executive Boulevard #300 Rockville, Maryland 20852-3803 Lewis Cahill, M.D. 31. Data filed (Month, Day, Year) 32. Registrer's Signatura

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State Registrar

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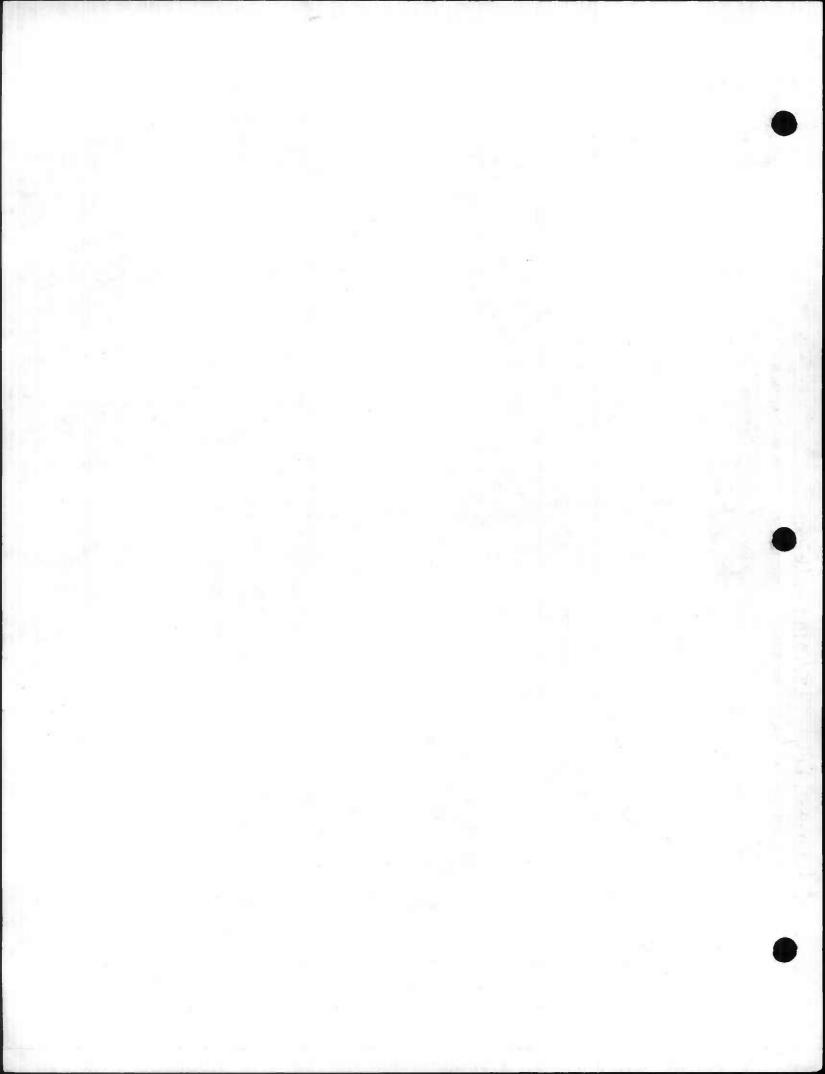
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ROY LAMAR 19 4:56 P.M. Dec. /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 18, 1914 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 100 M 2□ F 577 16 4579 Director Macon, GA. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b Counts 1√2 Yes 2 No Director 288-7 Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6505 14th Street, N.W. #301 United States 20012 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Dates: 1 Naver Married 2 Married ò 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: Black 3 ☑ Widowed 4 ☐ Divorced WW2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Law Enforcement 12 Maryland 18. Mother's Name (First, Middle, Meiden Sumame) 17. Fether's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Joseph Lamar Viola Sears 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Name/Relationship (Type, Print) Dwight Lamar 6505 14th St., N.W. #301, Washington, D.C. 20012 (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 12/23/99 Landover, Maryland 22. Name and Address of Facility
McGuire Funeral Service Inc. 21. Signature of Funeral Service Licensee 7400 Georgia Ave., N.W., Washington, D.C. ven 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Clause (Final 10 munice disease or condition resulting in death Examiner way arteroscle Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or es e consequence of). Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Mellitus 1 Yes 2 No 3 Probably 4 Unknown 24b. Were sutopsy tindings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 No 8 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ FVOutpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b Time of 28c. Injury at Work? Division 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after deat Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 6 a Funeral S Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only within 2 To the f å 29c. License number 29d. Date signed (Month, Day, Year) 30 5272 RIVER RO, #340, BETHESDA, MD. a and address of person who completed cause of death (Item 23a) (Type, Print) WALLACE OSEPH 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State **DEC 22**

DHMH 16 Ray 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Month **Physician** Lillian S. Lascoff December 17,1999 4:45AM /Medical 4a Facility Nama (II not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mannor Care Chevy Chase Chevy Chase Montgomery If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 10 M 20 F Yrs. Director 071-26-6413 91 July 30,1908New York Usual Rasidence of Decedant 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits ahow 1 ☐ Yes 2 ☐ No Directo 28a-1 Maryland Montgomery Chevy Chase 100 10a. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8 8700 Jones Mill Rd. 238 20815 United States Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: Name 2 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 72 hours after 1 Nevar Married 2 Married 8 1 Yes 2√ No Specify: Specify: "natural", edical Exa à 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Hygiene. Hygiene. Other than "n Elementary/Secondary (0-12) Collega (1-4or 5+) School Teacher Public Schools permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If lem 27 is marked oths any Injury or other traumatic event, pages. 17 Fathar's Nama /First Middle | ast) 18. Mother's Name (First, Middle, Maiden Surnama) Be Max Schatt Etta (Unknown) 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Sheila Leifer/ Daughter 9004 Levelle Dr. Chevy Chase, MD. 20815 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) eth David Cemetery 12/19 Elmont, NY. 21. Signatura a Fuperal Service/Leannee 22. Nama and Addrass of Facility Takoma Funeral Home. 254 Carroll St. NW. Washington, DC.20012 The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, saliura. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. **Physician** /Medical Immediata Ceusa (Finel Acute Cerebro Vascular Accident 3 Days disaese or condition rasulting in death) Examiner Due to (or as a consequence of): Examiner Severe Atherosclerosis Years physician and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enlar Underlying Cause (Disease or injury that initiated avants resulting in death) Last Dua to (or as e consequence of): Physician/Medical Dua to (or as a consequence of) 88 980 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. †CYes 2 No 3 Probably 4 Unknown Coronary Artery Disease by The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Dementia page 2 s 1 Yes 25tho 1 Yes 2 No Physician: 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) TO Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No this funeral 27. Mennar of Death 28a. Dela of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: After or Attending 5 Pending invastigation 1. Natural 2 Accident r deeth. 1 Yes 2 No hours after deeth uneral Director: 6 Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 4 Homicida filled in Hospital 24 hours **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier within 24 hou To the Fune completely fi (Check only onel the th 29b. Signatura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D31319 December 17, 1999

State Registrar

DHMH 16 Ray 6/95

Baltimore, Maryland 21215-0020

Box 68760

P.O.

Records.

Division of Vital

#103

Bethesda, MD.

8218 Wisconsin Ave.

32. Registrar's Signature

30. Nema and address of person who completed causa of death (Item 23a) (Type, Print)

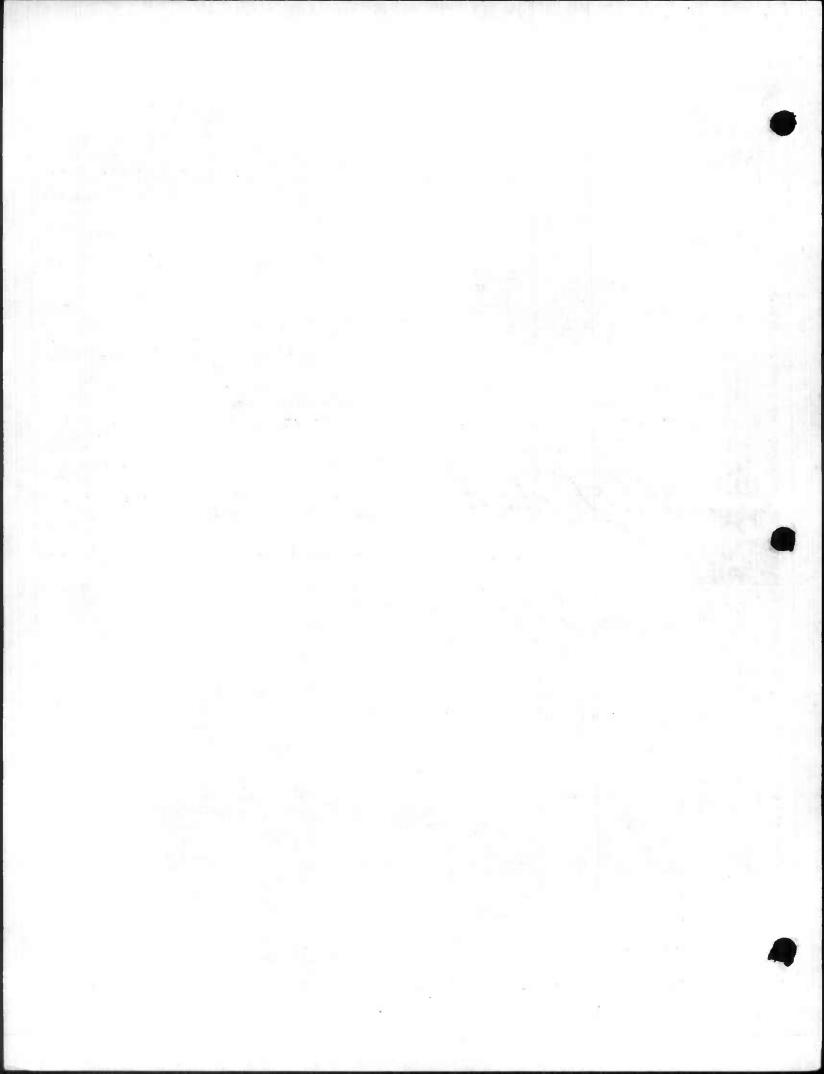
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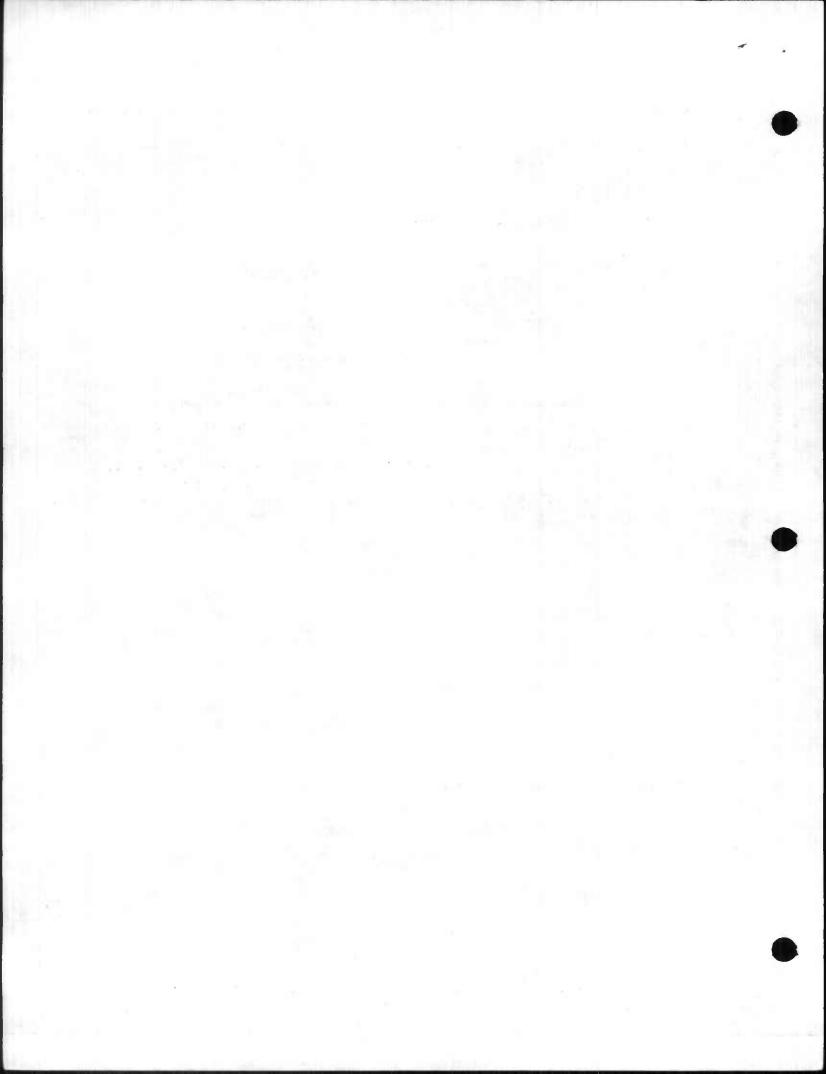
31. Data filed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 5:12 pm December 13, 1999 /Medical Agnes M. Lawson 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Takoma Park ar If Under 24 Hrs. 8. s Hours Min. Washington Adventist Hospital Montgomery If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1□M 20F 84 Yrs. Director 216-44-4221 May 18, 1915 Wisconsin Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow Nerns 23s or 28s-f sho 1 Yas 2X No Directo Maryland Prince George's Hyattsville 10f. Zip Code 10e. Street and Number 10g. Citizan of What Country? Funeral 1004 Chillum Road 20782 USA deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours effer of Department of Health and Mental Hygiene. Important: if them 27 Is marked other than "natural; or item any injury or other treumatic avent, the Medical Examinations. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specity: White P 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administration Office IRS 18, Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First Middle Last) Be Dominic Zawacki Avina Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Frank Lawson/ Husband 1004 Chillum Road, Hyattsville, MD 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 12/20/99 Brentwood, MD 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service Licens RACU Tuver 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . Septicemia Examiner Due to (or as a consequence of): Examine b Appendicitis attending physician and I for use as the buriel-transit deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Unknown signed t Strangulated right inguinal hernia Division of Vital Records. þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed performed Small bowel gangrene, Urosepsis page 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No Volume depletion, Malnutrition Physicien: 8 25. Was case referred to medical 26. Place of Death (Check only ona) Hospital: 1 □Vinpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 2 1 | Yes 2 No After this of 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred Certification: a or Attending P setter deeth. I Director: Atter t od in by the funer 5 Pending investigation 1 X Natural 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be detarmined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours effer To the Funeral Direct completely filled in by 4 Homicide WC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 🗸 05/083 12-17-1999 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Yisa O. Yussuf, 6712 Village Park Dr., Greenbelt, MD 20770 M.D. 31. Data filed (Month, Day, Year) 32. Registrar's Signature oaks DEC 20 Registrar

DHMH 16 Rev 6/95



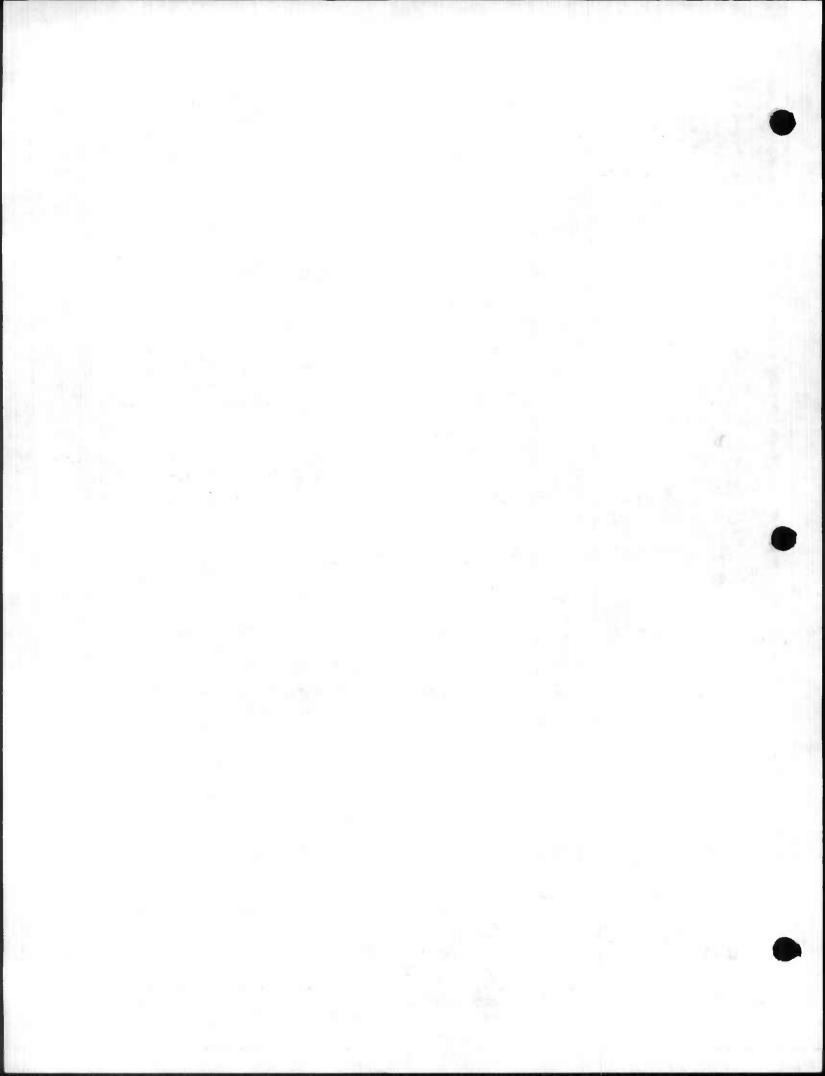
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death **Physician** December 17, 1999 Francis Theodore Leahy, Jr. 6:00 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carriage Hill-Bethesda Bethesda Montgomery If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Hours Months Days 10XM 2□ F 021-07-8925 89 Yrs. Director August 23, 1910 Massachusetts Usual Residence of Decedent the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits reast be notified at 1 ☐ Yes 2 1 No Director Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? , or items 23a or 9003 B Contee Road 20708 United States Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, the Medical Examiner Bleck, White, etc. filed within 72 hours after 1 Yes 2 □ No If Yes, Give 1 ☐ Never Merried 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 🗓 Divorced WWIT Yeer or Detes: natural Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. National Security College (1-4or 5+) 5+ Elementery/Secondery (0-12) Security Agency permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygies
Important: if Item 27 is marked other to
any injury or other traumatic avent, in
pages. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Francis Theodore Leahy, Sr. Marie Loughlin 2 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul R. Leahy/Brother 239 Commonwealth Avenue, Boston, MA 02116 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete cemetery, crematory or other place) 23, 1 N Buriel 2 □ Cremetion 3 □ Removel Irom State Dec. Old Calvary Cemetery Boston, Massachusetts 4 ☐ Donelion 5 ☐ Other (Specify) 1999 21. Signeture of Funerel Service Licenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc., 75 Bethesda, Maryland 20814-3501 7557 Wisconsin Avenue Essonen 5 M00672 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Cause (Final Coronary Heart Disease 9 Years disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner Chronic Atrial Fibrillation 9 Years physician and s the burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of) 8.8 attending for use as P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, by Completed 24b. Were autopsy findings available prior to 24a. Wes an sutopsy Deed completion of cause of death? pege 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attanding Physician:
 A hours after death.
 Funeral Director: After this certifically filled in by the tuneral director. Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Panding 1 ☐ Yes 2 ☐ No Investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1\(\) Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and side of certifier 29d. Date signed (Month, Day, Year) 29c. License number D01948 December 20, 1999 ets of person wito or pleted cau of death (Item 23a) (Type, Print) MCD. Blaine Fitzgerald, 8218 Wisconsin Avenue, Bethesda, Maryland 20814-3107 Date liled (Month, Dey, Year)
DEC 23 32. Registrar's Signeture State 1999

DHMH 16 Rev 6/95

Registrar



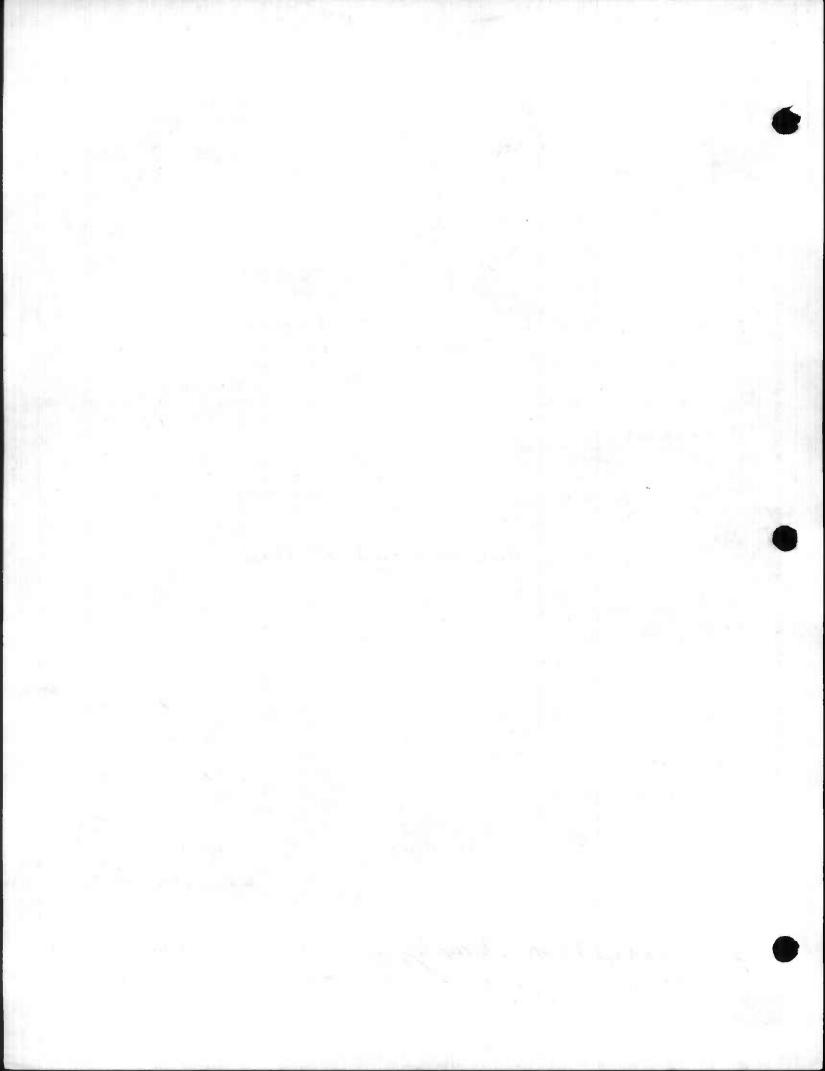
Robert Stephen Lewis

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State of Maryland / Department of Health and Mental Hygiene

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			C	ertificate of	Death	,	Reg. No.	2 41004		
	1. Decedent's Name (First, Middla, Las	t)				2. Date of Dea	ath Day	3. Time of Death		
Physician /Medical	ROBERT ST	EPHEN LEWIS				Decembe		999 04:37 AM.		
Examiner	4e Facility Name (If not institution, give				4b. City, Town, or		4c. County	of Death		
	Prince Geor	ge's Hospital	Cent		Chever		Princ	ce George's		
uneral irector	217-23-9566	7. Age (In yrs	. last birthda 24 Yrs.	Months Day:			y, Year)	9. Birthplaca (State or Foreign Country) NASHINGTON, D.C.		
	Usual Residence of Decedenf 10a. Stete 10b. County	10c. C	ity, Town or	Location				10d. Inside City Limits		
Director	MARYLAND PRINCE				1 ☐ Yes 2XXINo					
uneral Dire	10e. Street and Number 7605 GLENSIDE D	RIVE	10f. Zip Code 20912					10g. Citizen of What Country? U.S.A.		
by Funeral	11. Marifal Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 [X ‰ If Yes, Give Year or Dates:	J,S. 1:	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ K		Specify Yes or No- to Rican, etc.)	Black	- American Indian, c, White, etc. BLACK		
pete	15. Decedent's Edi (Specify only highest grad	ucation da completed)	16a. Dec	cedent's Usual Occi	upation e during most of wo	orkina	16b. Kind of Bu	siness/Industry		
ygene, er than 'natur t, the Medical. Completed	Elementary/Secondary (0-12) 12th grade	College (1-4or 5+)		va kind of work don DO NOT use retir			CLOTH	ING		
Be C	17. Father's Name (First, Middla, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumami	9)		
10	RUSSELL M. LEWIS				CHRI	STINE BU	RNETT			
	19a. Informant's Name/Relationship (T	ype, Print)	19b. Ma	illing Address (Street	et and Number or R	ural Routa Numbe	er, City or Town,	State, Zip Code)		
	Russell M. Lewis/	Father	760	05 Glensi	de Dr., S	ilver Sp	ring, Mo	1. 20912		
	20a. Method of Disposition 1 ☐ Burial 2 ☒️Xremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State	cematery, c	position (Nama of ramatory or other pi AKE CREMA		Date 12/23		City or Town, State		
SUCE	21. Signature of Funeral Service Licans			22. Name and Add	HORTON CO	MORTIC	IANS' II	VC. .; DC 20011		
ian cal ner	fmmediete Cause (Finat disease or condition resulting in death)	a. Gunshot		sequence of):	of che	st	+			
edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	C								
1	resulting in deeth) Last	d								
y Physicia	Part fl. Other significant conditions co	ntributing to death but not re	sulting in the	underlying cause of	given in Pert i.	23b. Dld 1	lobacco use con	tribute to the cause of death?		
by Physician/N		The state of the s					Yes 2 No	3 Probably 4 Unknown		
pleted						24a. Was perio	an autopsy med?	24b. Were autopsy findings available prior to completion of cause of death?		
Com						1,200	res 2□No	120 Yes 2□ No		
Be Gio.	25. Was case referred to medical examiner?				26. Place of De	eth (Check only o	na)			
dire	12 Yes 2 No	Hospital: 1 ☐ Inpatient 20	ER/Outpat	ient 3□ DOA C	other: 4 Nursing	Home 5 ☐ Resid	denca 6 □Othe	er (Specify)		
ton:	27. Manner of Death 1 Natural 5 Panding 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	/ W	uryat ork? ⊒Yes 2,227No	28d. Describe I	now injury occurr	ed - (- t		
Certification:	3 Suicide 6 Could not be determined	building, etc. (Spec	1031 nome, farm, ify)	street, factory, office	0	1	Subject was shot 281. Location (Streat and Number or Rural Routa Number. City or Town, Stata) 17th + C street, NE			
edical		raician: To the best of my kn iner: On the besis of examin and manner stated.			ceuse(s) and ma					
completely filled in by the fune Medical Certification	29b. Signature and title of certifier	4		29c. Lice	nse number		29d. Date signed	(Month, Day, Year)		
	Stysh.	1 Nas	Ny	1011	C.M.E.		Decemb	er 19, 1999		
	30. Name and address of person who co	completed cause of death (Ite		e, Print) 11 Penn S	Street, B	altimore,	Maryla	nd 21201		
State egistrar	31. Date filed (Month, Day, Year) DEC 2 3 19	32. Registrar's Sign	eture \mathcal{G}	Soors	2					



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

								Death	- Wichtai II	Reg. No.	19	41835	
Physician	Decedent's Name (First, A								2. Date of I Month	Day	Year	3. Time of Death	
/Medical		AN		LIN					DEC.	-	999	10:00 A	
Examiner	4a Facility Neme (If not Insti			er)			(4b. City, Town, o	or Location of De	ath 4c. County	of Death		
	HOLY CRO				for a foliation	, Willod	er 1 Year	SILVER	SPRING		TGOM		
Funeral Director	5. Social Security Number 592–16–9565 Usual Residence of Deceder	4	X 2□F 7.	79	last birthday Yrs.	Months		Hours M	in. (Month, I	18, 1920	9. Birth	place (State or Forei ntry) INA	
fand g #	10a. State 10b. County 10c. City, Town or Location											10d. Inside City Limi	
ather death with the Maryland or lisms 23a or 28a-f show miner must be notified at Furneral Director	MD. MOI	TIGOME	ERY			STLVE	R SP	RING				1∑Yes 2□N	
or 28e-6 s be notified Director	10e. Street and Number			10f. Zip Code						10g. Citizen of What Country			
Sa control of D	3310 N.	LEISU	JRE WORL	RE WORLD BLVD. #124 20906						Ţ	S.A.		
r hema 23 slover, must	11. Maritel Status			2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes o		(Specify Yes or I		a - Ameri	can Indian,				
ed within 72 hours after ser then 'natural', or fit it, the Medical Examina Completed by Fu	1 Never Married 2 3 Widowed 4 Divo	1 Tes 2 If Yes, Give	1 ☐ Yes 212 No				Specify:	eno rican, etc.)		Black, White, etc. Specify: ASIAN			
	15. Deci (Specify only h	dent's Edu			16a. Dece	dant's Us	ual Occup	ation during most of v	on 16b. Kind of Busines			dustry	
Men o	Elementary/Secondary (0-		College (1-4	or 5+)	lile.	DO NOT	use retired	during most or v	voiking				
Hygier Hygier Bher th mt. Ba			4			ARC	HITE			PRIVATE		E	
Be Be	17. Father's Name (First, Mic	dle, Last)						18. Mothar's N	lama (First, Midd	ma (First, Middle, Maiden Sumame)			
Monid Monid Monid Monid To	YUAN	JII							SU TZE	YANG			
2 sh and le m	19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Numb								Rural Route Nun	nber, City or Town	, Stata, Zij	o Code)	
and lealth m 27 her tr	YUN CHEN I	IN/W]	FE	100	SA	-		TEM #1	0	1			
T to a	20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremat	ion 3 🗆 R	Removal from Sta		Place of Disponentery, cre	matory of	other plac	(e)	Date	20c. Location	- City or Ti	own, Stata	
Pages nert of ant: if the ury or o	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) PARKLAWN MEMORIAL PARK 12/28/99 ROCKV										KVIL	LE, MD.	
Depart Import any in	21. Signature of Funerat Ser	rice Licens	al land	2 _{M00}				ss of Facility				2090 PRING, MD	
Physician /Medical Examiner	Immediate Cause (Finat disease or condition resulting in death)	ı	WIDE		EVS7 or as a conse			IC CH	RCINOM	4		148	
filcate be assecuted giphysician and as the burial-transit edical Examiner	Sequentially list conditions, if any, laeding to immediate cause. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of):												
= 0 6													
at the death cert of by the attending setached for use a Physician/M	Part II. Other significant con	ditions cor	tributing to deat	h but not re-	not reculting in the underlying cause given in Part I			23b. Did tobacco use contribute to the cause of dear					
that the de ed by the a detached i	Part II. Other significant conditions contributing to death but not resulting in the underlying or							1			☐ Yea 2 No 3 ☐ Probably 4 ☐ Unkno		
by by	LIVER MOTIF	KOXIA	XIA, WOAKNESS				as an autopsy	24b. W	fera autopsy finding				
The law require sate has been single 2 should Completed										formed?	CC	vailable prior to empletion of cause death?	
cate he									10	Yes 2 No	1	☐ Yes 2☐ No	
ysician: The sector, page conflicate	25. Was casa rafarred to me examinar?		losnital:				0		Death (Check only	ona)			
T digital	1 Yes 12 No 27. Manner of Death t Natural 5 Pe	nding	28a. Date of 1 (Month,		28b. Time of Injury	of	28c. Injur Wor	y at k?	1	sidenca 6 Oth e how injury occur		fy)	
tal or Attending P rs after death. al Director: After t led in by the funers Certification:	3 Suicide 6 □ Co	estigation uld not be	28e. Place of	loiury - At h	ome farm of	M reet fecto		Yas 2□No	28f. Location	(Street and Numi	ber or Rur	al Route Number	
after Direct Dir	4 ☐ Homicide Ge	armined	building	etc. (Speci	(y)	1001, 1001	ry, omos			own, State)			
Hospi 24 hou Funer tely fill	(Check only 2 Med	ifying Physical Examin	ner: On the basis	s of examina	owledge, deat ation and/or in	th occurre	d at the tin	ne, date and pla pinion, deeth oc	ice, end due to the	e cause(s) and m	anner as :	stated. to the causa(s)	
within 2 To the comple	29b. Signatura and title of ce	titier	and manner	stated.		2	9c. Licens	e number		29d. Date signe	ed (Month	Day, Year)	
Com	255. Organization and title of 66	7 1	11.	MAX		-		252		DECEMBE			
80	Den	1 Ill	M	141_	7		-04	ack.		PECEMBO	1	/11/17	
	30. Name and addrass of per	HRIY	A, MD,	1/SD/	GEOR	Print) G1A	NE	STE 51.	5, WHOM	TON MD	209	02	
State Registrar	31. Date filed (Month, Day, Y		32. Reg	Istrer's Sign	eture	Loon	1/2/						

DHMH 16 Rev 6/95

CC:C. C. L. III , and the state of the state of

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State of Maryland / Department of Health and Mental Hygiene

ene 99 41836

				Ce	rtificate	of	Death		F	leg. No.	~	41030
		1. Decedent's Name (First, Middle, Last)							2. Date of Dee		Vees	3. Time of Death
	Physician	Samuel Kayson			Decembe	r 17, 1	L999	11:36 AM				
	/Medical Examiner	4a Facility Name (If not Institution, give s	street and number)				4b. City, Tox	wn, or L	ocation of Death	4c. County		
	2,4,1111101	6111 Montrose Road	kvi	ille Montgomery								
	Funeral Director	5. Social Security Number 6. Sec. 123	Months	1 Year Days					9. Birthplace (State or Foreign Country) Poland			
7		Usual Residence of Decedent										
death with the Maryland	or 28a-f show be notified at Director	Maryland Montgo		ity, Town or L Roc	kville							1 ☐ Yes 2 No
W (I) W	23a or 2 ant be n	10e. Street and Number 6111 Montrose Road	, #719		10f. Zip 0		852			Og. Citizen of V United		
d 21215-0020		3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puert			gin? (Sp , Puerto	Specify Yes or No- to Rican, etc.) 14. Race - Amer Black, White Specify: Wh			etc.	
25.0	lical lical	15. Decedent's Educ (Specify only highest grade	16a. Dece	16a. Decedent's Usual Occupation (Give kind of work done during most of working				ina	16b. Kind of Bu	usiness/In	dustry	
17 mg	ygiere. Ne than *neturn II, the Medical.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)								
N	Con Con	12			Groo	cer					cery	
Maryland	202 %	17. Father's Name (First, Middle, Last)					18. Mothe	r's Nam	e (First, Middle,	Maiden Suman	10)	
aryla	markad markad markad	Abrom Kayson					Sti	she	Lepman			
a a		19a. Informant's Name/Relationship (Ty		-					ral Route Numbe			
	1 27 pg tr	David Kayson/Brothe					ill Ro	ad,	#323Nor	th, Bet	hesd	a,MD 20814
Baltimore,	Pages 1 and 2: nant of Health at etc. If New 27 Is any or other tray	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cre	pose of Disposition (Name of Dete Dete, crematory or other place) gomery Crematorium, Inc. 1999 Dete Dete Dete Dete Dete Dete Dete Det						laryland	
Balt	Departi Importa any inj ansa	21. Signature of Funeral Service Licensu	MOO6	70 B	ethesd	a-0	hevy (Chas	ert A. e, Inc. 20814-	, 7557	y Fur Wisco	neral Home/ onsin Avenue
3.1	nysician Medical xaminer	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Arterioscl			of dyi	ng, such as	cardiac	or respiratory an	rest,	1	Approximate Interval Between Onset and Death
rifficate be assouted	ettending physician and for use as the burial-transit ctar/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of):									
OXE	ding		J									
n f	for u										-	
P.O.	signed by the attend d be detached for us d by Physician/	Part II. Other significant conditions con		23b. Did tobecco use contribute to the cause of								
of Vital Records, P.O. Bo Physician: The law requires that the death	2 ahoui piete							24a. Was a	an autopsy med?	av	ere autopsy tindings vailable prior to impletion of cause death?	
T e									1 D Y	es 2K) No	1[☐ Yes 2☐ No
<u>a</u>	rector, per	25. Was case referred to medical					26. Place	of Dea	th (Check only o	ne)		
Of VITA Physician:	I direc	axaminer? 1 ☐ Yes 2 💢 No	lospital:] ER/Outpatie	nt 3 DO/	A Ot	her: 4 Nu	rsing H	ome 5 Resid	ence 6 Oth	er (Specit	(v)
ON OI	ith. : After this s funeral di	27. Manner of Death 1 XNaturel 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of		Bc. Inju			28d. Describe h		-	,,
DIVISION al or Attending	within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di Medical Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci		reet, factory,	office			28f. Location (S City or Tow		er or Run	al Route Number,
Me Hospit	n 24 hour he Funer pletely fills edical		ician: To the best of my known: On the basis of examination and manner stated.									
Tota	To the common	29b. Signature and title of certifier		29d. Date signe	d (Month,	Day, Year)						
	15	30. Name and fiddress of person who co	mpleted cause of death (Ite	m 25a) (Type	, Print)	D	09946			Decembe	er 20	, 1999
		Henry Roth, M.D.,				et,	Rockv	i11	e, Maryl	and 208	352	
IT	State	31. Date filed (Month, Day, Year)	32. Registrar's Sign		lo	180 4	1/2/					

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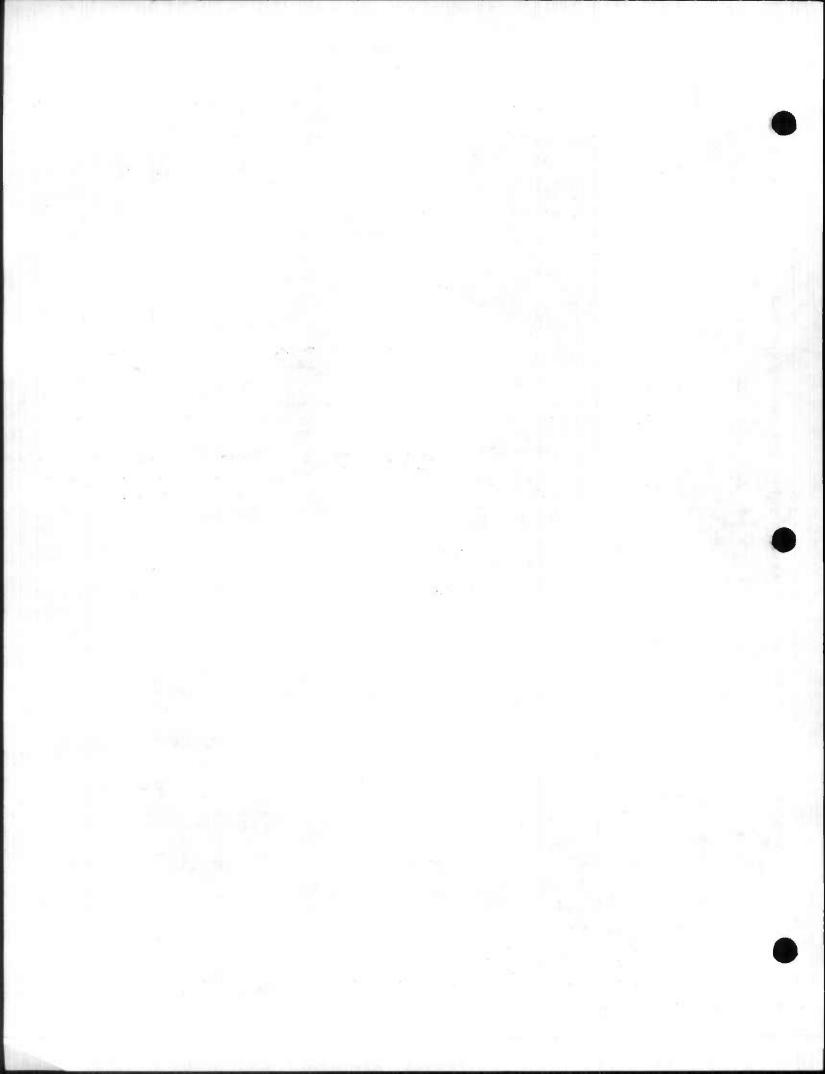
State of Maryland / Department of Health and Mental Hygiene 0.0 1.1007

	1. Decedent's Name (First, M.	iddle I act		Cer	tificate of	Death		Reg. No.		Time of Court	
Physician		LUD WALL					2. Date of De Month	ER 14,	Year	3. Tima of Deeth	
/Medical	ROBERT M. 4a Facility Nama (If not institu	KLINE	d number)			4b. City, Town, or				4:45AM	
Examiner	3508 GREENCAS		a mannosi y		BURTONSV:				7		
	5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Year	r If Under 24 Hrs				e (State or Foreign	
Funeral Director	578-46-9849 Usual Residence of Decedent	6. Sex 1 M 2□	F 64	Yrs.	Months Days	Hours Min	FEB. 8	th Year) 3, 1935	PENNSY	LVANIA	
r 28a-f ahow noutred at	10a. State 10b. County 10c. City, Town or Location BURTONSVILLE									Inside City Limits 1 ☐ Yas 2 ☐ No	
289	10e. Street and Number				10f. Zip Code			10g. Citizen of V	itizen of What Country?		
23a or	3508 GREENCAS	TLE ROAD			20866	5	4.0	USA			
or tems	11. Merital Status 1 Never Merried 2 Nover Merried Nover Merr	Aarried 1 🖎	Decedent Ever in Ud Forces? /es 2 No 19. s, Give or Dates: 19.	04	/as Decedent of Yes, specify Cul	Hispanic Origin? (S ban, Mexican, Puar Specify:	pecify Yes or No- lo Rican, etc.) 14. Rece - American I Bleck, White, etc. Specify: WHIT				
natur offert	15. Dece (Specify only hig	dent'a Education phest grade comple	(ed)	16a. Deced	ent's Usual Occu	pation during most of wo	rking	ing 16b. Kind of Business/Industry			
de de	Elementary/Secondary (0-1: 1.2	2) Colle	ge (1-4or 5+)		TECT/DRA			CONSTR	UCTION		
Be Co	17. Father's Name (First, Midd	fle, Last)		1110111	THOT/ DIG		me (First, Middle				
permit. Pages I and a should be rised with Department of Heelth and Mental Hygiena. Important: if item 27 is marked other than any injury or other traumatic avent, the Monca. To Be Comp	MILTON A. KLIN	E				ANNA T	HERESA K	EMMERER			
	19e. Informant's Name/Reletionship (Type, Print) SWANEE LOU KLINE (SPOUSE) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 3508 GREENCASTLE ROAD BURTONSVILLE, MD										
other other	20a. Method of Disposition		120b. I	Place of Dispos	ition (Name of		Date	20c. Location -			
7 0 1	1 Burial 2 Cremetic		rom State VER	A CRUZ	EVANGEL.	ICAL 1	2-18-99	EMMAUS,	PENNS	YLVANIA	
important: if any injury or pncs.	21. Signature of Fusieral Serv		1 1/900		ONAL CEN	ress of Facility NE	C-DIMAII	T 11800	MEU U	AMDOUTER	
any phoe	12/1	7/1/1	Note			LVER SPRI				AMPSHIKE	
	23a. Pert1. Enter the disease shock, or heart leilure.	or complications 1	hilt caused the dea						A	proximete	
/sician	shock, or heart leilure. (List only one catine	on each line.						In O	tervel Between nset and Death	
ledical	Immediate Cause (Finet disease or condition		HEPAT	IC FAIL	URE				. 2	-MONTHS	
miner	resulting in death)	ā		or as a consequ							
			HEPAI	OMA					6	-MONTHS	
s tha burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or as a consequence of):								
	Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a consequence of):								
d by the attending letached for use. Physician/M		d									
ed by the adetached f	Part II. Other significant cond	litions contributing	to death but not res	sulting in the un	derlying cause g	iven in Pert I.	23b. Dld	tobacco use co	ntribute Io th	e cause of death?	
P de ty							10	Yes 2/1 No	3 Probab	oly 4 Unknow	
D De S								an autopsy ormed?	availa	autopsy tindings ible prior to letion of cause ath?	
200										es 2□ No	
hes been signe 3e 2 should be d mpleted by							10	Yas 2KNo	1111		
page 2 should be c	25. Was case referred to med	ical				26. Place of De	eth (Check only		1 1 1		
s certificate has been signe director, page 2 should be d	25. Was case referred to med examiner? 1 Yes 2 No	Honoitst	I ☐ Inputient 2 ☐	ER/Outpatient	3□ DOA O	ther	eth (Check only of	one)			
nis certificata has been signe il director, page 2 should be d To Be Completed by	examiner? 1 Yes 2 (No 27. Manner of Death	Hospital:	late of Injury	28b. Time of	3LI DOA	ther: 4 Nursing I	eth (Check only of Home 5 A Resi	one)	er (Specify)		
director, page 2 should be To Be Completed by	examiner? 1 Yes 2 No 27. Manner of Death 1 Statural 5 Per 2 Accident	Hospital: 28a. E		1	28c. Inju	ther: 4 Nursing I	eth (Check only of Home 5 A Resi	one) dence 6 □Oth	er (Specify)		
for the this contitions has been signed the funeral director, page 2 should be down the funeral director. To Be Completed by	examiner? 1 Yes 2 (No 27. Manner of Death 1 Statural 5 Per 2 Accident inve 3 Suicide 6 Cou	Hospital: 28a. C	late of Injury	28b. Time of Injury	28c. Inju	ther: 4 Nursing I ury al ork? Yes 2 No	eth (Check only of the second	one) dence 6 Oth how injury occur	er (Specify)	louta Number,	
this certificate has been signeral director, page 2 should be director. To Be Completed by	examiner? 1 Yes 2 (No 27. Manner of Death 1 Statural 5 Per 2 Accident inve	Hospital: ding stigation at not be armined 28e. If hing Physician Act at Education of a Standard Sta	late of Injury Month, Day Year)	28b. Time of Injury oma, farm, stre	28c. Inju	ther: 4 Nursing I	eth (Check only of the control of th	dence 6 Oth how injury occur Street and Numb wn, State)	er (Specify) red er or Rural R	ad	

State Registrar

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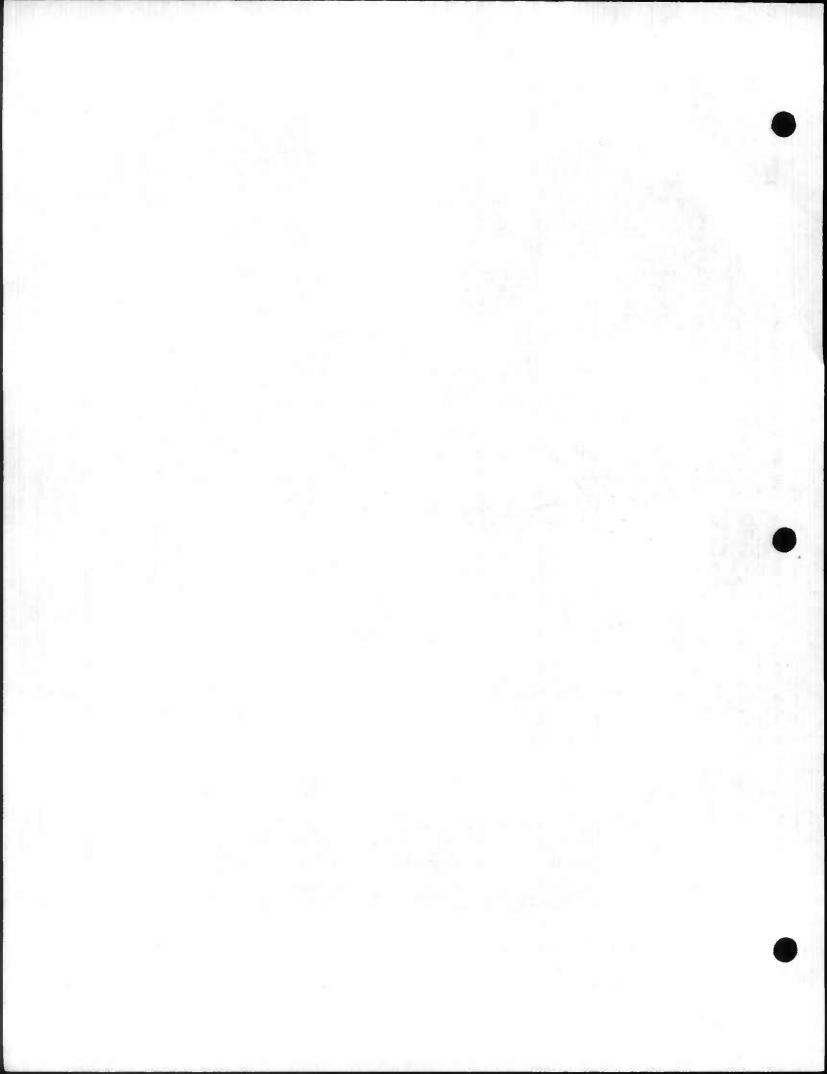
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					ate of	Marylai		artment of F rtificate of			Reg. No.	9 4	1838	
ıysician Medical		1. Decedent's Neme (First, Middle, Last) John Kuchta									ber 20,	Year	Time of Death 11:05 AM	
miner eral tor	5. Se	7126 R1v 0cial Security N 9-30-92	ver Ro umber 50		7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hr		rs. 8. Date of E (Month, I	Mon	9. Birthplace	(State or Foreign				
1		Usual Residence of Decedent 10a. State 10b. County 10c. City, Too					ty, Town or Lo	ocation				10d.	Inside City Limits	
to	Ma	ryland	Monto	gomery		7	Bethe	sda					1 ☐ Yes 2 ☒ No	
Directo		Street and Nur			13/		11-17	10f. Zip Code		1 - 1-1	10g. Citizen of United			
	11.1	126 Riv Merital Status		12. Wes Decedent Ev Armed Forces?			J,S. 13.	20817 Was Decedent of It If Yes, specify Cub	Hispanic Origin? an, Mexican, Pu	(Specify Yes or I erto Rican, etc.)	No- 14. Rac	ce - American I	ndian,	
	3	☐ Never Merri			☐ Yes 2 Yes, Give 'ear or Dat	1		1 ☐ Yes 2 ₹☐ No Specify: Specify:						
Deletion			ify only highe	1	npleted)	45-1	16a. Deced (Give life.	dent's Usual Occup kind of work done DO NOT use retire	pation during most of w d)	16b. Kind of B	usiness/Indust	ry		
-	E	ementary/Seco	ndary (0-12)		college (1-4	40r 5+)	Cler	gyman			Religi	Religion		
Þ	17.1	John Ku		Last)						ame <i>(First, Midd</i> aret Har	lle, Maiden Surname) Vest			
P	19e	19e. Informent's Neme/Reletionship (Type, Print) Helen Kuchta/Wife							Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, River Road, Bethesda, Maryland 20817					
eny injury or other treumatic event, pncs. To Be C		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State						ce of Disposition (Name of leder, cremetory prother place) of Ascension Dec. 23, Frackville, Pennsylvan						
	21.	Signature of Fu	A Service	Licensee		M0019	RC 75	Name and Address bert A. 57 Wisco thesda,	Pumphrey	y Funera	1 Home/B	ethesda		
	Imm	shock, or hear	rt failure. List Finel	r complicatio t only one ca	use on ea	used the dee ch line.	th. Do not ent	er the mode of dyi				On	proximete ervel Between iset and Deeth	
Jer.	Due to (or as a consequence of):													
/Medical Examiner		uentially list cor y, leading to im se. Enter Unde se (Disease or initiated events liting in death) L	rtying injury	6 d			or as a conseq							
Physician/Me	Pert	II. Other signifi	cent conditi	ons contribut	stributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death?				
Phys													ly 4 Unknow	
Completed by											as an autopsy rformed?	evailal	eutopsy tindings ble prior to etion of cause th?	
Ó										10	Yes 2 No		es 2 No	
8	25. \	Nas case references			el.			l Ou	har	eath (Check on)				
Certification: To	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Special Control of the Con								rred	oute Number,				
edical C	29a.	Certifier (Check only one)	1⊠ Certifyii 2□ Medical	Examiner: (: To the b	is of examine	owledge, death	n occurred et the ti vestigation, in my	me, date and pla opinion, death oc	ce, and due to the	ne cause(s) end m e, date and place,	enner as state and due to the	d. e cause(s)	
Mex	29b.	Signeture and	title of contra	Pos	ent		m	29c. Licens DO 4	se number		29d. Date signe December			
	Da	niel Ro Dete filed <i>(Mont</i>	senblu	m, M.E	. 10	0400 C	onnect	Print) icut Aver	nue, Ken	sington	, Marylar	nd 208	95	
State strar	31. L		DEC 2			gistrar's Sign	- /.	. Spor	6/					

DHMH 16 Rav 6/95



J-7666-031 Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Sang Tip Kwon Certificate of Death Amend #1,12/29/99,BMW,Montg.Co. 1. Decedent's Name (First, Middle, Last)
Jip 2. Data of Death 3 Time of Death Day **Physician** Sang Tip Kwon December 20, 1999 10:00 P.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda 7. Age (In yrs. last birthday) If Under 1 Year | If Undar 24 Hrs. | 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1X M 2□ F Yrs. 216-31-3036 76 Director Jan. 7, 1923 Korea **Usual Residence of Decedent** 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits me 23s or 28s-f short must be notified at 1 ☐ Yas XIX No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4521 East West Highway Funeral 20814 United States 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yas 2 XXVo
If Yes, Give Bema Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 21215-0020 ò 1 ☐ Yas 2XXNo Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Datas: "natural". Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Businass/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Teacher Education Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental H antt: If hern 27 is marked oth Seung J. Kwon You S. Kim 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Sue Kwon - Daughter-in-Law 13713 Valley Oak Circle, Rockville, MD 20850 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 8 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 12-23-99 Silver Spring, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 in plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, one cause on each line. Approximate Interval Between Onset and Death Physician Immediata Cause (Final disease or condition resulting in death) /Medical · Winner Dynniss Examiner Due to (or es a consequence of): Examiner buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Dua to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of) use as the been signed by the should be detached Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part It. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ page 2 should Completed 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? this certificate has 1 es 2 No 1 PYes 2 No al or Attending Physicien: The after death.

Director: After this certificate ed in by the funeral director, pa 25. Was case referred to medical 8 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | TER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Ves 2 No Certification: To 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division Approx 1600 M 5 Pending 1 Natural 12-20-99 1 Yas 2 No DRUGNOECAN investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide ROBONAY RIVERST MONTGOTTHY CO _ HO) To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the causa(s) end mannar es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. edical 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and titla of certifie 29c. License number O.C.M.E. December 21, 1999 Mupite 3 Name and address of person who completed cause of death (Item 23a) (Type, Print)

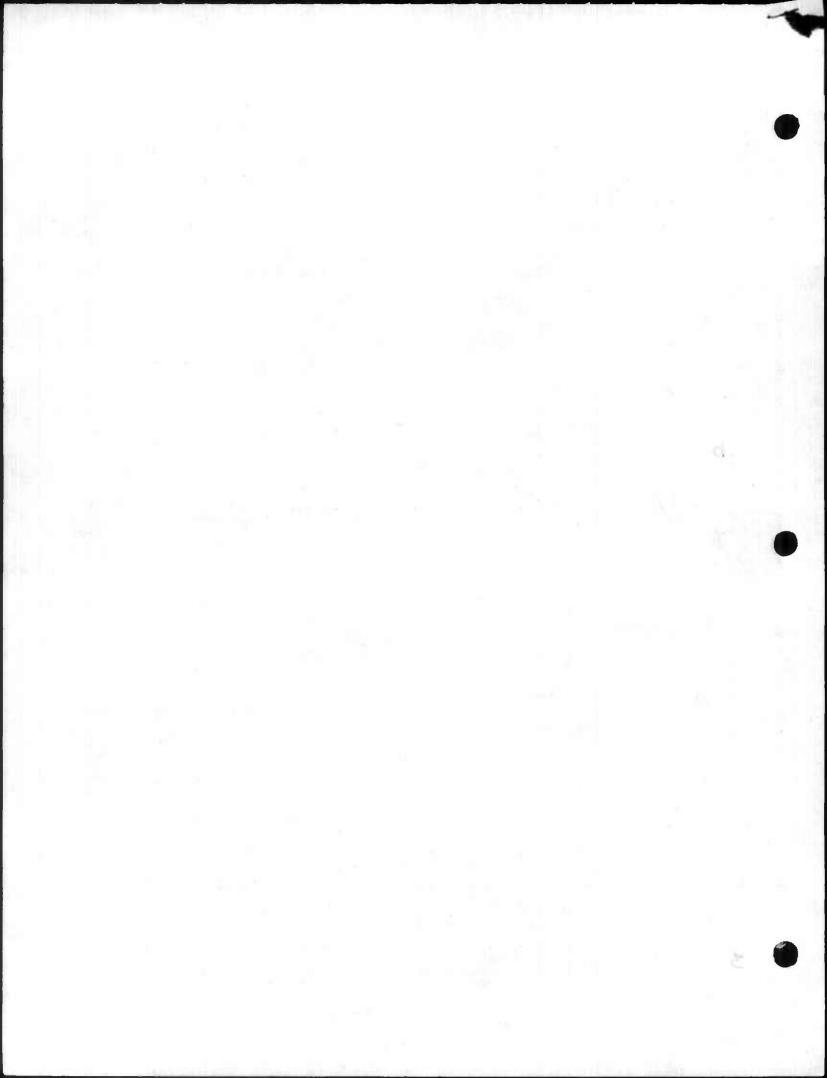
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Registrar

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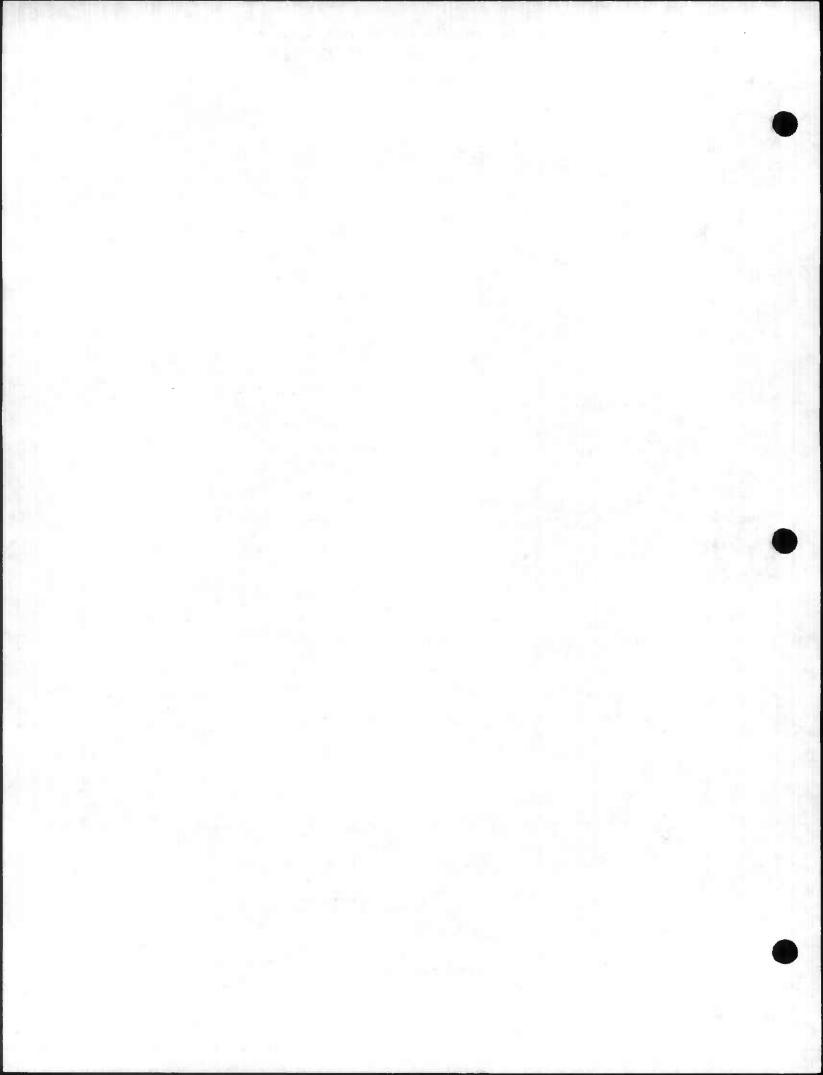
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State of Maryland / Department of Health and Mental Hygiene

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Physician	Decedent's Neme (First, Middle, La JEROME MARTI					2. Deta of Death Month DECEMBER	Dey Year 25, 199			
/Medical Examiner	4a Facility Nema (If not institution, giv 701 EAST CHARLES		7 770		4b. City, Town, or LC		4c. County of De	eth		
*Funeral Director	5. Social Security Number 6. S	Sex 7. Aga (In yrs. last birthdaj Yrs.	Months Dey	r If Under 24 Hrs. s Hours Min.	8. Dete of Birth (Month, Dey, Ye ptember)	9. B	irthplace (State or Foreign Country)		
Maryland I show led.at	Usuel Residence of Dacedent 10a. Stete 10b. County MD Charl		10d. Inside City Limits							
or 18a-f s be notified Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What Country?				
urs after death with the Maryin alf, or itsms 23s or 28s-f sho Examiner must be notified at by Funeral Director	15 W Hawthorne 11. Meritel Stetus 1 Never Merried 2 Married	12. Wes Decedent Ev Armed Forces? 1 Yas 3 No If Yes, Give	er in U,S. 13	2064 Wes Decedent of If Yes, specify Cu	Hispanic Origin? (Sp ben, Mexican, Puerto	Specify Yes or North Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White				
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B MARK	17. Father's Name (First, Middle, Last, John Matthew I.					e (First, Middle, Mai Jouise Mi		rualea		
ahould ind Men imerke umerke To	19e. Informent's Neme/Reletionship (*	19b. Me	ling Address (Stre	et and Number or Run					
and 2 and har tra	Joan Higgs/Sis	ter			Harbor Dr			,MD 20677		
Pages 1 nent of har ary or oth	20a. Method of Disposition 1 ☐ Buriel 2 ☐ Crametion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif.			emetory or othar p			Port T	r Town, Stete		
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certificate be executed ding physician and use as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Undarrying Cause (Disease or Injury that initiated events resulting in death) Lest	. Fatty	Me of the following the follow	tame	rphosi	5 04	- th	e		
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ysician: The la s certificate ha director, page fo Be Com	25. Was case referred to medicet examiner?	Hospital:				h (Check only one)	1			
Attending Physician: or death. ector: After this certific by the funeral director, iffication: To Be (27. Menner of Death 1	Hospitel: 1 ☐ Inpatient 28e. Date of Injury (Month, Dey)	28b. Time	of 28c. tn		ome 5 Residence 28d. Describe how		pecify)		
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To the within To the compl	29b. Signature and titla of certifiar	tann	M. T		C.M.E.		Data signed (Mo DECEMBER	nth, Dey, Year) 27, 1999		
	30. Name and address of person who	completed ceuse of dee			Baltimore	e, Marylar	nd 21201			

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth **Physician** Mary 8:15 am 2 Lem 20 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death **Examiner** Hospital Center Cheverly, MD Prince George S rince 8. Date of Birth (Month, Dey, Year) If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthpleca (Stete Country) or Foreign **Funeral** Months 1□M 2XX Days Hours Min 367-20-9699 Director Sept. 25, 1920 Michigan Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f ahow 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits important: If itam 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examinal must be notified at Maryland Prince Georges Bladensburg 1 ☐ Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4202 58th AVE. 20710 U.S.A. Funeral 12. Wes Decedent Ever in U,S.
Armed Forces

1 ☐ Yes 2 ☐ No
If Yes, Give
Yeer or Detes: 14. Race - Amarican Indian, Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 11. Maritel Stetus Bleck, White, etc. NX Never Married 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☼No Specify: Specify: Asian þ 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highast greda completed) College (1-4or 5+) Elementary/Secondery (0-12) 4 Nurse Health Care 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middle, Last) Arthur Chee Lem Sukvee Or 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Dorothy L. Lee/Sister 273 Old Kensico Rd. White Plains, NY 10607 20b. Place of Disposition (Neme of cemetery, cremetory or other place)

Metropolitian Crematory Dec. 23,1999 Alexandria, VA 20a. Method of Disposition 1 ☐ Buriel XX Cramation 3 ☐ Removal from Stata 4 ☐ Donetlon 5 ☐ Other (Specify) 21 Signature of Funerel Servica Licania 22. Name end Address of Fecility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 elbou disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onsat and Death Physician /Medical Immadiata Causa (Final diseesa or condition resulting in death) Examiner Examiner sician and burial-transit requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760, physician Physician/Medical the 50 USB signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to complation of cause of deeth? Completed 24e. Was an eutopsy hes page 2 1 Yes 2 No 1 ☐ Yes 2 No certificate Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4☐ Nursing Homa 5☐ Residence 8☐ Other (Specify) 2 1 Yes 2 No 1 1 Inpatient 2 ER/Outpetient 3 DOA After this funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Dey Year) 28d. Describe how Injury occurred 28b Time of 28c. Injury at Work? Certification: 1 Natural 5 Pendina after death. Director: Aft 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) end manner as steted.

2 Medicat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. edicai 29a, Certifier To the To the To the 29b. Signature end title of caryfier 29d. Dete signed (Month, Dey, Year) 29c. License number Hend 30. Name and address of person who completed cause of death () tem 23e) (Type, Print) Hospital Drive, Cheverly KALANTARINIA KAMBIZ 3001 31. Dete filed (Month, Day, Year) 82. Registrer's Signature State **DEC 2 3 1999** Registrar

pour de france

DEC 2 \$ 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Day 1999 Year Dec 21, **Physician** 1:58 A.M Edna O'Dea Lloyd /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Prince George's Clinton Bradford Nursing Home 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours 1□ M 2□ F Yrs. Aug 11, 1900 99 Washington DC Director 578 66 6159 Usual Residence of Decedent with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itama 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No MD Clinton P.G. Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 20735 United States 7403 Bershire Drive death Funeral 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? filed within 72 hours after 1 ☐ Yes ② No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: p 3 Nidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed v Department of Health and Mental Hygien Important: if item 27 is marked other th any Injury or other traumatic event, that once. Homemaker Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be Edith Cantor Lawrence O'Dea 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 7407 Bershire Drive, Clinton, Maryland 20735 Mary L. Willoughby (DAUGHTER) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removel from State Cedar Hill Cemetery Dec 28, 1999 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Lee Funeral Home, Inc 6633 Old 21. Signature of Funeral Service I Alexandria Ferry Road, Clinton, Maryland 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** ACUTE PNEYMONIA /Medical Immediate Cause (Final 3 DAYS disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and s the burial-trensit The law requires that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es a consequence of) P.O. Box 68760. Physician/Medical Due to (or as e consequence of) 50 signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown HYPERTENSION Division of Vital Records, þ CORONARY ARTERY DISLASE 24b. Were autopsy findings avellable prior to completion of cause of death? 24e. Was an autopsy Completed i certificate has b 200 No 1 ☐ Yes 1 ☐ Yea 2 ☐ No Attending Physician: funerel director, 25. Was case referred to medical examiner? 26. Piece of Death (Check only one) Be Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1) Natural 2 Accident 5 Pending death. 1 Yes 2 No after death Director: A d in by the f investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certifier 11999. 12/21 728281 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6B Industrial Park Dr., Waldorf,,D 20602-2746 Nelson V. Benjers, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 2 1999 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Andrew 9:16AM Matuskey December 17, 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Columbia Howard County General Hospital Howard 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 1,1923 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** XXM 2DF Yrs. 233-34-2630 Director 76 Czechoslvaki Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Director Maryland Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 8090 Woodloo Dr. 21043 United States 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Amed Forces 1 12 Yes 2 | No H Yes, Giva Year or Dates: 1941-45 hours after 1 Never Married 2 Married 8 دن Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: py Specify: 3₺ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hydro Electric Engineer Private 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Pages 1 and 2 should be fit ment of Health and Mental H tant: If Nem 27 is marked off lury or other traumatic even 8 Andrew Matuskey Maria (Unk.) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Ralationship (Type, Print) Michael Matuskey/ Son 9192 Windflower Dr. Ellicott City, MD21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State
4 Donation Specify) Department of Important: If any injury or ance. King David Memorial 12/20 Falls Church, VA. 21. Signatury of Fun ral Service Licenses 22. Name and Address of Facility Stein Hebrew Funeral Home. 232 Carroll St. NW. Washington, DC.20012 autus he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, earl failure. List only one cause on each line. 236 Parti Approximate tnterval Between Onset and Death **Physician** /Medical Immediate Cause (Final Ventricular Arrhythmia (Vent Tachycardia/Fib) disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine Congestive Heart Failure/ Cardiomyopathy physician end the burial-transit be axecuted Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Causa (Disease or injury that initiated evants resulting in death) Last Due to (or as a consequence of): 68760 Mitral Valve Replacement Physician/Medical Due to (or as a consequence of): Mitral Regurgitation Box 950 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably ★StUnknown Coronary Artery Disease of Vital Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? page 1 Yes 2√ No 1 Yes 2 No 8 25. Was case referred to medical 26. Placa of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) edicai Certification: To 1 ☐ Yes 2 No 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attanding 1 Natural
2 Accident 5 Pending investigation Injury death. 1 Yes 2 No Director: 6 Could not be datarmined 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 \ Homicida To the Hospital within 24 hours To the Funeral I completely filled Hospital 29a. Certifier 1⊠ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2□ Medicat Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)
DEC 17 1999 29c. License number 29b. Signature 10 Carres 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Registrar

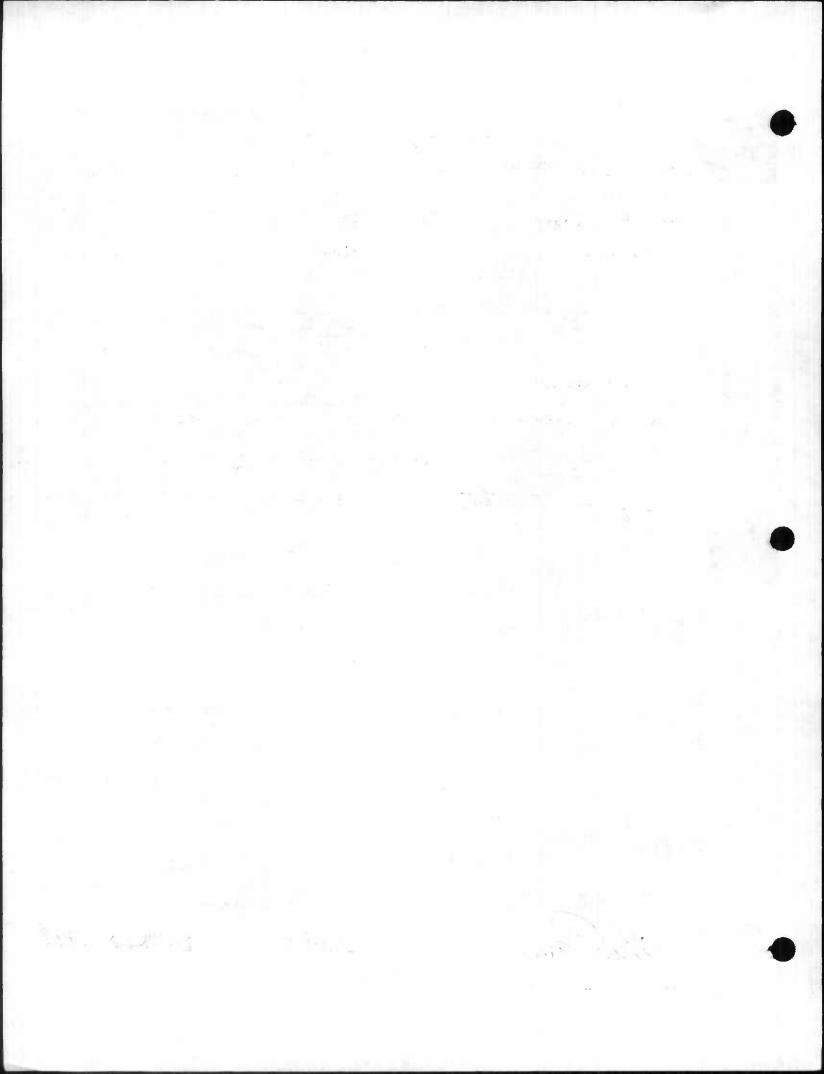
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31. Date filed (Month, Day, Year)
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32. Registra

William Parnes,

s, MD. 11085 Little Patuxent Pkwy. Columbia, MD. 21044
32. Registrar's Signature

6. Sports



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						(Certifica	te of	Death		Reg. No. 9 9	Ls	1844
Dh		Decedent's Name	e (First, Middle, Li	ist)						2. Data of De Month	ath Day	Year	3. Time of Death
Physicia /Medic	-	JAMES R	. McCABE							DECEMB			8:50 P.M.
Examin	45.1	Facility Name (/	f not institution, gi	a street and numi	ber)				4b. City, Town, or	Location of Death	4c. County	of Death	
			RIENDLY V)				BURTONSV		MONTG		
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		. Method of Disp		27 5011	20b.	Place of E	Disposition (A	lame of		Dete	20c. Location -		
Page 1			☐ Cremation 3 ☐ 5 ☐ Other (Speci		ale		CO NAT	- Alexandra		12/23/99	TRIAN	GLR.	VA
Baltimore permit. Pages 1 (Department of He important: If Item any Injury or oth	21.		neral Service Lice	••	1 90		22. Name HINES-	and Addre	ess of Facility LDI FUNER	CAL HOME	INC.		
		line	ling &	NI R	le							RING,	MD 20904
	23	shock, or hea	nt feilure. List only	one cause on ea	ch line.	nn. Do no	ot enter the m	ode or dy	ing, such as cardia	c or respiratory a	rest,	1	Approximate Interval Between Onset and Death
Physician /Medical Examiner	dis	mediate Cause (ease or conditio sulting in death)	Final n	· Ad	Due to (nsequence o	0 F	the e	soplay	US	1	3 menths
	G Ca	quentially list come ny, leading to imuse. Enter Unde use (Disease or t initiated events	injury	C			nsequence o						
\$ p.#	Physician/Medi	ulting in death) l	Last	d									
deeth od for	Par	t II. Other signifi	icant conditions	contributing to dea	th but not re	sulting in 1	the underlying) cause gi	iven in Part I.	23b. Dld	tobacco use cor	ntribute to	o the cause of death?
requires that the deeth cereen signed by the ettendir hould be deteched for use	by Phy									10	Yea 2 No	3 Pro	bably 4 Unknown
	Completed										an autopsy med?	av	fera autopsy findings vallable prior to empletion of cause death?
VICAL TREC sician: The law certificate has t lirector, page 2 s	Co									10	ras X⊠ No	10	☐ Yes 2☐ No
clan: clan: entific ector.	25.	Was case reference warminer?	red to medical	Manadada						eth (Check only o	one)		
F S S S S S S S S S S S S S S S S S S S	2	1 ☐ Yes 2 ☐		Hospital: 1 In		ER/Outp	2.30	JUA		Homa XX Resi			y)
Ing After	<u>o</u> 27.	Manner of Death 1 X Natural	5 Pending	1	Day Year)	28b. Tii	me of ury M	28c. Inju	iry at ork?]Yes 2∐No	28d. Describe	how injury occur	60	
To the Hospital or Attending Phy within 24 hours efter death: To the Funeral Director: After this completely filled in by the funeral d	Certification:	2 Accident 3 Suicide 4 Homicide	investigetio 6 Could not to determined	8 28e Place o	f tnjury - At I j, etc. (Spec	nome, farr ify)	n, street, fect			28f. Location (City or To		er or Rur	al Route Number,
To the Hospital of within 24 hours evithe Funeral Completely filled		I. Certifier (Check only one)	Certifying Pl	nysician: To the b niner: On the bas and manne	is of examin	owledge, ation and/	death occurre or investigation	d at the ti	ime, date and place opinion, death occ	e, and due to the urred et the time,	cause(s) end me date and place,	nner as a and due t	itated. o the ceuse(s)
To the		. Signature and	title of certified				2	9c. Licen	se number		29d. Date signe	d (Month,	Day, Year)
10+1		m	1/0	4 mc)			03	5162		12-2	Z-99	ì
10.	30.		ess of person who	The second second second					UITE 200	STLVFR			
Ctot	24	Date filed (Mont			istrar's Sign			-		OTHARK	D. II. III.	2	
Stat Registra	c		FC 23 1		enever		9. 1	souk	2				

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 99 1, 191, 5

						Cei	tificate o	f Death		Reg. No.	-/ 6	41019
	Dhusia	ion	1. Decedent's Nema (First, Middla, Las	1)					2. Data of I		Yeer	3. Tima of Death
	Physic /Medi		May B. Mitchel	.1						ber 17,		10:30 PM
	Exami		4e. Facility Neme (If not institution, give	street end number)				4b. City, Tow	n, or Location of De	ath 4c. Count	y of Deeth	
			Collingswood Nur	sing Home				Rockv	ille	Mont	gomer	У
	Funerai Director		5. Social Sacurity Number 6. Se 578-44-3684	7. Age □M 2X F	82	Yrs.	If Under 1 Yas Months Day		Min (Month.	Birth Dey, Year)), 1917	Cour	lace (State or Foreign stry) sinia
200	8 m		10e. Stete 10b. County		10c. City, T	own or Lo	cation				1	0d. Inside City Limits
Mary	6.5	ō	Maryland Montgom	ery	Gaith	nersb	urg					1 ☐ Yes 2 X No
å	28	Je C	10e. Street end Number				10f. Zip Code			10g. Citizen of	What Cour	itry?
w.ii	3a o	0	9701 Fields Road,	Apt. 2102				20878		United		*
11215-0020 Within 22 hours after death with the Mandand	Department of Health and Mental Hygiene. Important if Item 22a or 28a-f show any Injury or other traumatic event, the Medical Examinet must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 N If Yes, Give Yaar or Detes:			Vas Decedent of Yes, specify Cu		in? (Specify Yes or Puerto Rican, atc.)	No- 14. Ra Bia Specif	ce - Americ ck, White,	
20-0	a fr		15. Decedent's Edu	ucetion	1	6e. Deced	lent's Usual Occ	upetion		16b. Kind of B	iusiness/Inc	dustry
Maryland 21215-0020	than "n	Completed	(Specify only highest grad Elementery/Secondary (0-12)	College (1-4or 5	*		kind of work don DO NOT use retii Stered N		of working	Hosp	ital	
D	Hyg Hyg	BeC	17. Fethar's Neme (First, Middla, Last)	<u>_</u>		NC GI	occied i		's Neme (First, Midd	-		
<u>a</u>	ked ic ev	To B	George Bywaters					Venus	Fawcett			
ary	N pur	-	19a. Informent's Name/Reletionship (7)	ype, Print)	1	19b. Mailin	g Address (Stree	et end Number	or Rural Route Nun	nber, City or Town	, State, Zip	Code)
Z 2	alth a		Martha M. Krause/D	aughter	8	315 L	ake Stre	eet, Oa	k Park, I	llinois	60301	
Baltimore,	ant of He it: If Item y or other		20e. Method of Disposition 1 ☐ Burial 2 ☒ Cremetion 3 ☐ F 4 ☐ Donetion 5 ☐ Other (Specify)		came	etery, crem	sition (Neme of netory or other pi Crematoria		Dec. 21,			
Baltii	Departm Importan any Injur		21. Signature of Fugeral Service Licens	00	01126	22	Name and Add	ress of Fecility	1999 Robert A. 300 West		y Fun	eral Home/
			At at			Ro	ckville.	Maryl	and 20850	-2805	CLY A	venue,
6			23a. Pert1. Enter the disease, or compleshock, or heert failure. List only o	lications thet caused ne ceuse on eech lin	tha death. [e.	Do not ente	ar tha mode of dy	ying, such as c	ardiac or respiretory	errest,		Approximeta Intervel Between
21	nysician Medical xaminer		Immediete Ceusa (Finel diseese or condition	Phen	mia							Onset end Deeth
	Adminer	J	resulting in deeth)		Due to (or es	a conseq	uence of):					
8	a tie	ine		b. Live	r to	elen	re					Y REEVS
x 68760, entificete be executed	ettending physician and for use es the burial-transit	Examiner	Sequantially list conditions, if any, leeding to immediate		Dua to (or es	e conseq		C 0				
68760,	ician		Ceuse (Disease or injury	c. Cons	estive	- He	early .	faulur	~			Years
387 cete	phys s the	edicai	that Initieted avents resulting In death) Last	Q _L	Due to (or as	a consequ	uence of):					
	ding se es	3	9 9 9	d							i	
. Bo	etten for u	clar									1	
o g	0 2	Physician	Pert II. Other significant conditions con	ntributing to death bu	t not resultin	g in the un	derlying ceuse g	jiven in Pert I.	23b. Di	d tobacco use co	ntribute to	the cause of death?
م ق	igned by the ettendin be deteched for use	by			<u></u>				1[Yes 2 No	3 Prot	pably 4 Unknown
Records, P.O le law requires that the	s been si 2 should	Completed								es en eutopsy formed?	eve	ore autopsy findings bileble prior to inpletion of ceuse deeth?
m e	nte he	ПО							10	Yes 22 No	10	Yes 2 No
<u>=</u>		Be	25. Wes casa referred to medicel examinar?					28. Place	of Deeth (Check only	v one)		
of Vita Physician:	i dire	2	1 Yes 2 No	fospitel: 1 Inpatier	t 2 ER/	Outpatient	3 DOA 0	ther: 4 Nurs	sing Home 5□Re	sidenca 6 □Oth	ner (Specify	()
C 2	- e	Certification:	27. Menner of Deeth 1. Neturel 5 □ Pending 2 □ Accident investigation	28e. Dete of Injury (Month, Dey	Year) 281	b. Tima of Injury		uryat ork? ⊒Yes 2 □ N	- A	e how Injury occur	rred	
DIVIS	226	ertific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At homa (Specify)	, farm, stre	et, factory, office	•		(Street end Numb own, Stete)	ber or Rura	l Route Number,
- Hospita	within 24 hours ef To the Funeral Di completely filled in	29a. Certifier (Check only one) 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and menner stated.									enner as st end due to	eted. the ceuse(s)
othe	vithin Fo the	Me	29b. Signeture end title of certifier				29c. Licar	nsa number		29d. Dete signe	d (Month, I	Dey, Year)
A	12		Solly W-	Y	ND			1584	3	Decemb	er 2	o nd 1999
			30. Name and address of person who co	moleted cause of de	eth (Item 93	a) (Tunn F	Print)	1001	3 Gouther			
			SAMEH ALY	481 N-E	-Ved o		AVE.	#230	Garther	sburg 1	102	4480
	Sta	•	31. Dete filed (Month, Day, Year)	32. Registrar				, ,				

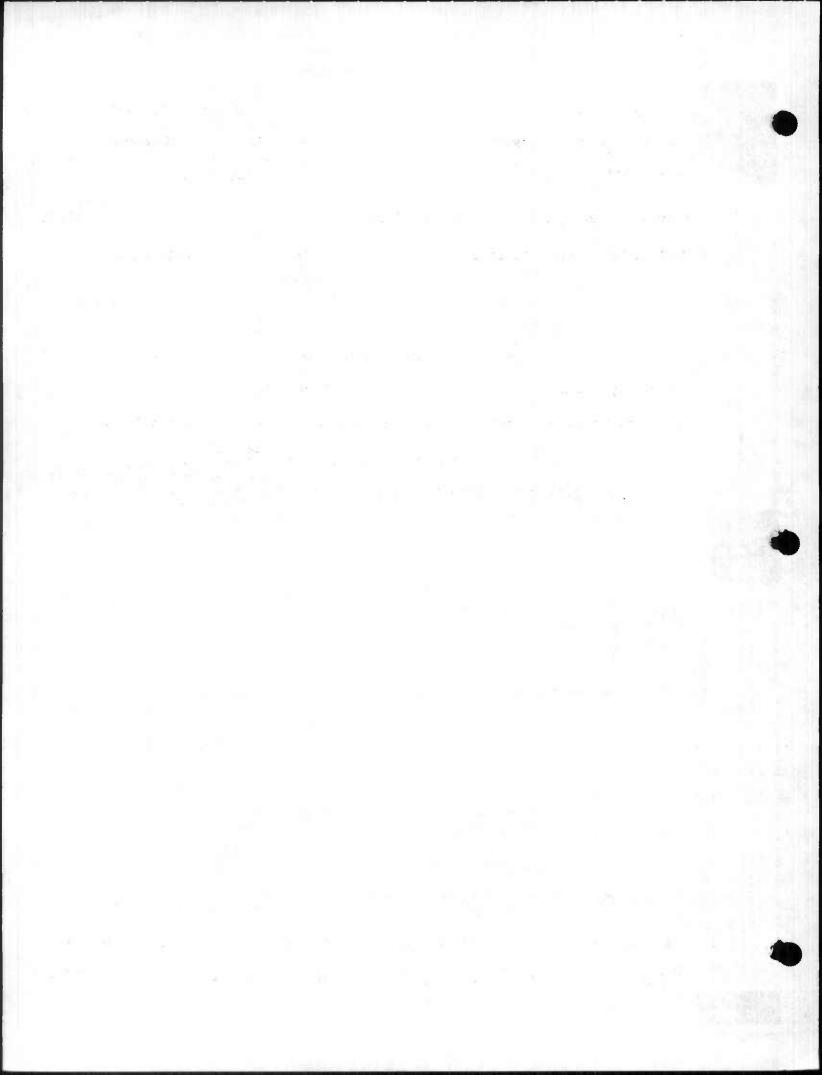
32. Registrar's Signeture

6. Sports

DHMH 16 Rev 6/95

State

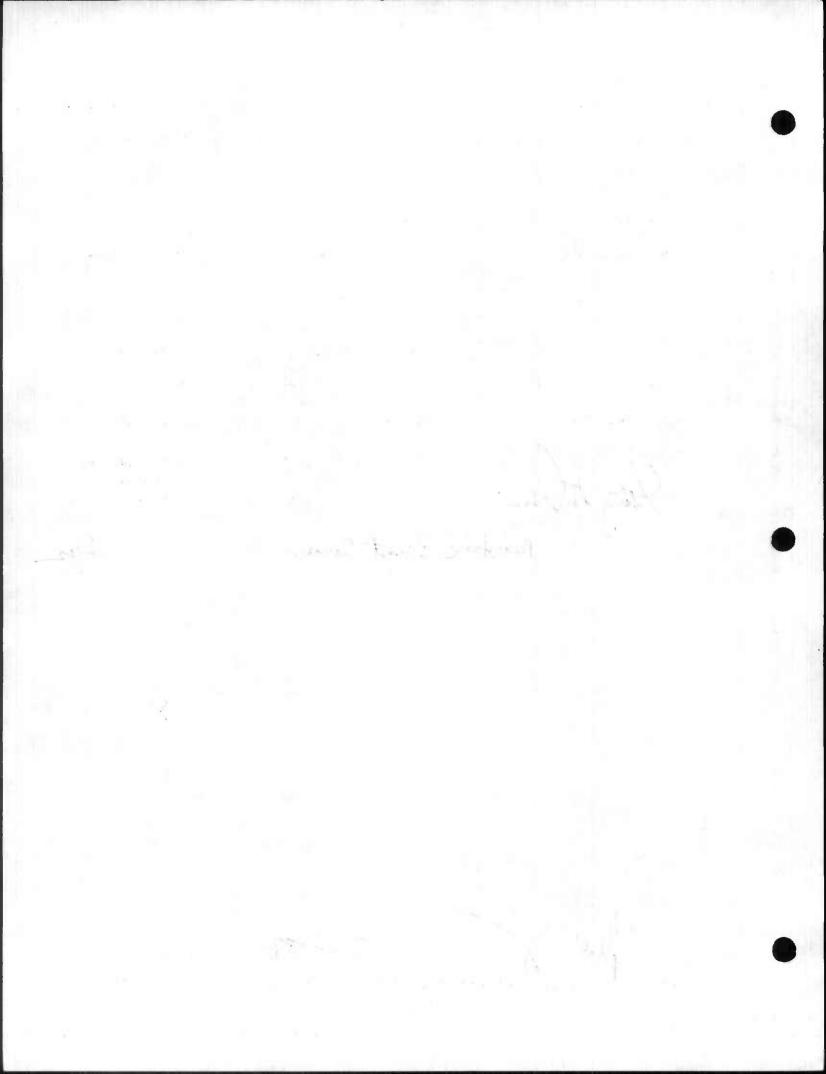
Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 9 Certificate of Death

1.	1	0	,	-
4	1	O	i	6

						Death		Reg. No.			
Physician /Medical	Decedent's Nama (First, Middle LORETTA	F.		MORDER	S			BER 16, 1	Yaar 1999 1	Time of Death 1:00 P.M	
Examiner	4a Facility Nama (If not institution						or Location of Dea				
	MANOR CARE OF S	-	-	do not bringle do 1	If Under 1 Year		SPRING		GOMERY	10:	
Funeral	578-10-4735	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 91	Yrs.	Months Days		fin. 8. Data of B (Month, L Sept 2	Day, Year)	Gountry)	gton, DC	
Director	Usual Rasidance of Decedant	Λ	91				Sept 2	23, 1900	wasnin	gton, Do	
show stat	10a. Stata 10b. County		10c. Ci	ty, Town or Lo	cation				10d.	inside City Limits	
28e-f sho notfiled at rector	Maryland Montg	omerv		Derwo	od					1 ☐ Yas 2 ☑ No	
be notified Director	10e. Street and Number	J			10f. Zip Code			10g. Citizen of	What Country?	,	
10	6908 Horizon Te	rraco			208	55		United States			
Puneral Funeral	11. Marital Status		edent Ever in U	J.S. 13.			(Specify Yas or N		e - Amarican I		
F	1 Nevar Married 2 Marr	Armed Fo	2 X No		If Yas, apecify Cul	oan, Mexican, P	(Specify Yas or Nuarto Rican, atc.)	Bla	Black, Whita, atc.		
by	3 ☑ Widowed 4 □ Divorced	It Yas Gi	va		1 ☐ Yas 2 🎇 No	Specify:		Specify	White		
	15. Deceden	t's Education		16a. Dece	dent's Usual Occu	pation		16b. Kind of B	usinass/Indust	ry	
Completed	(Specify only highan Elemantary/Secondary (0-12)	st grada completed)	(Apr E)	(Giva	kind of work done DO NOT use retin	during most of add)	working				
E	8	College (1-40r 5+)	Esta	te Liqui	dator		Estate	Sales		
BeC	17. Father's Nama (First, Middla,	Last)				18. Mother's	Name (First, Middl	le, Maiden Surnan	na)		
ToB	Wilmer	Farran				Lore	tta	Mansfi	ield		
-	19a. informant's Neme/Relations	hlp (Type, Print)		19b. Meilie	ng Addrass (Stree	at and Number of	r Rural Routa Num	ber, City or Town,	, Stete, Zip Co.	de)	
r traumatic svent, To Be C	Vivian Jean O'N	eil. dau	ghter	6908	Horizon	Terrace	. Derwoo	od, MD 2	20855		
e de	20a. Mathod of Disposition		20b. 1	Place of Dispo	sition (Nama of		Date	20c. Location	- City or Town,	Stata	
5	1 Burial 2 Cramation 4 Donation 5 Other (S	3 Proposal from	Stata		natory or other pl eaven Ce		12/20	C + 1	Consider	MD	
-BOUCE	21. Signifure of Furneral Service		Gat		2. Nama and Addr		1999	Silver		, MD	
9	1.4	th.						Funeral			
	Jarry M	Jour					Dr., Gait			20877	
cian dical diner	23a. Part1. Entar the depase, or shock, or haamatura. List immediata Causa (Final disaasa or condition resulting in deeth)	Nets	static	Bree	est Car					erval Batween eset and Death	
ةِ الله	resulting in death)		Due to (or as e consec	quence of):					0	
Examiner	Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants	D	Dua to (d	or as a consec	quence of):						
use es the bunal-transit n/Medical Examir	that initiated evants rasulting in death) Last	c	Dua to (d	or as a conseq	uance of):		7,11			Y	
Completed by Physician	Part ii. Other algnificant condition	ona contributing to de	eath but not res	ulting in tha u	ndarlying causa g	iven in Part i.	23b. Di	d tobacco una co	ontributa to the	e cause of death?	
Phy Phy							10	Yaa 2 No	3 Probab	ly 4 Unknown	
by P							-	-			
ted out							24a. Wa	is an autopsy formed?	availal	autopsy findings ble prior to	
- S									of daa	etion of cause th?	
hes been s ge 2 should mpleted							10	Yes 2 No	1 DY	as 2 No	
mo		1				26. Place of	Death (Check only	one)			
e Comp	25. Wes case refarred to medical	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA	ther	g Home 5□Ra		nar (Specify)	F1 - J - A	
irector O Be	25. Wes case refarred to medical axaminar? 1 ☐ Yas 2 ☒ No	1 1 1		28b. Tima o							
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funeral director	axaminar? 1 ☐ Yas 2 ☒ No 27. Manner of Death 1 ☒ Neture! 5 ☐ Pendin 2 ☐ Accident investig	28a. Date getion	of Injury th, Day Year)	Injury				o non injury occur			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 41847 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3 Time of Death December 18, 1999 7:50AM John E. Murphy 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 6. Sex 1X M 2 ☐ F If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 8. Data of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Days Yrs. Aug. 29, 1920 Massachusetts 029-03-9471 Usual Rasidence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yas 2 No Maryland Montgomery Rockville 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 195 Leland Street 20850 United States 12. Was Decedent Ever in U.S. Armed Forcas? 1 월 Yas 2□ No World H Yas, Giva Yaar or Datas: War II 14. Race - American Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: War II 3 Midowed 4 Divorced White 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlega (1-4or 5+) 12 Pharmaceuticals Salesman 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) John J. Murphy Alice Foley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Patricia A. Perryman/Daughter 195 Leland Street, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, State Dec 22 1 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 1999 Gate of Heaven Cemetery Silver Spring, MD 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 M00803 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death PNEUMONIA Immediata Ceusa (Final disease or condition resulting in death) Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Diseasa or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Due to (or as a consequence of): Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2€ No 3 Probably 4 Unknown CONGESTIVE HEART FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ATRIAL FIBRILATION

certificate be executed physician and s the burial-trans

Box 68760.

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

ahow!

1 23a or 28a-f sh

Hems.

'natural', or

filed within 72 hours after

permit. Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: If Nem 27 is married other tha any Injury or other traumetic

Physician

Examiner

/Medical

Baltimore, Maryland 21215-0020

Dir

Funeral

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Completed

Be

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After t or Attending after death.

Director: Aft d in by the fur To the Hospital or within 24 hours aft To the Funeral Di completely filled in edicai

Certification: To

10+

State

25. Was casa rafarre	ed to medical		26. Place of Death (Check only one)											
examinar?	10	Hospital: Inpatient 2	☐ ER/Outpatient	3 🗆 🖸	OA Other: 4	☐ Nursing I	lome 5 Residence 6 Othe	(Specify)						
27. Mannar of Death 1 Divaturel 2 Accident	5 Pending Invastigation		28b. Tima of tnjury	м	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury occurre	od .						
3 ☐ Suicida 4 ☐ Homicide	6 Could not be datermined	28a. Place of Injury - A building, etc. (Spe	t homa, farm, stree	t, facto	ry, office		28f. Location (Street and Number City or Town, State)	or or Rural Route Number						

id tha of certifiar

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steled.

GROVE

us and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number 29d. Data signed (Month, Day, Year) DECEMBER 18 1999 D 28656

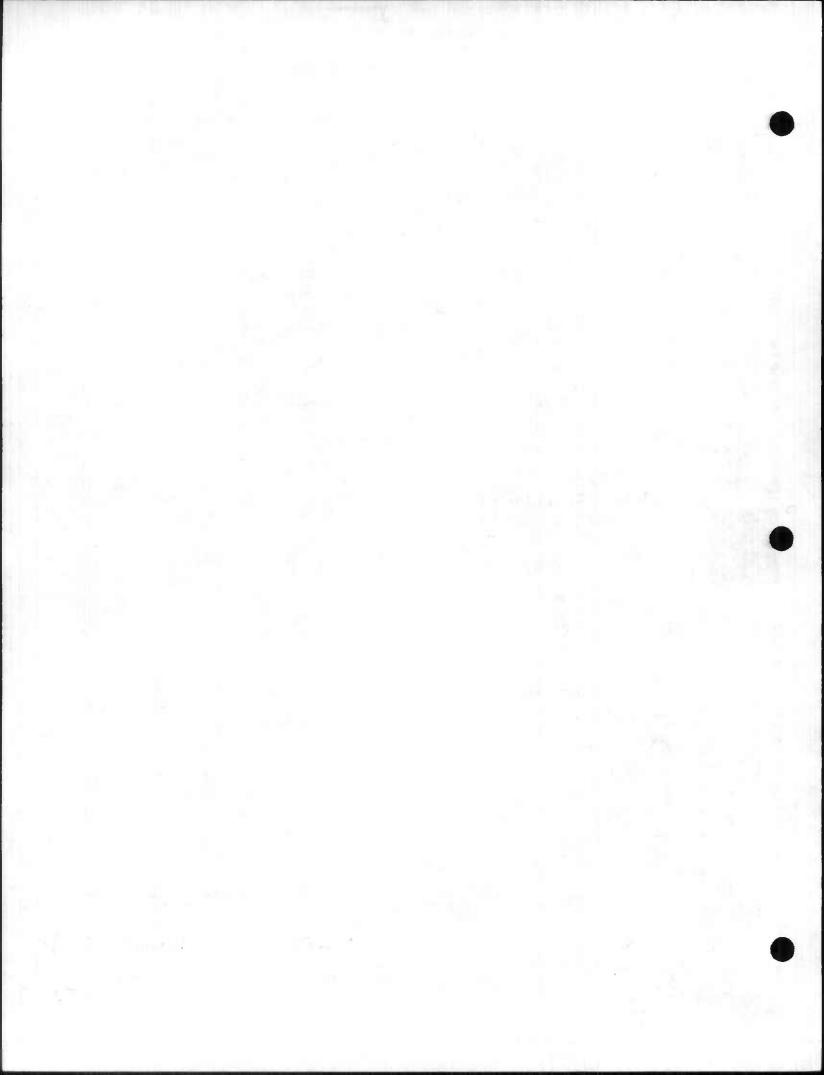
ROAD #208 ROCKVILLE

MD20850

MASSI 15225 SHADY MD

31. Data filed (Month, Day, Year) 32. Registrar's Signatura

Registrar



State of Maryland / Department of Health and Mental Hygiene 0 0 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Month **Physician** Marie T. Maynard 8.50 PM DECEMBER 20 1999 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Westminster Carroll Carroll County General Hospital 5. Social Security Number If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 11 1920 Rentucky 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplece (State or Foreign Country) 1□ M 25 F Months Deys Hours 79 402-16-7756 Yrs. Director Usual Residence of Deceden with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show treumstic event, the Modical Examiner must be notified at MD Carroll Westminster 1 Yes 2 No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4275 Arthur Shipley Road 21157 USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Maritel Stetus Pages 1 end 2 should be filed within 72 hours after nent of Health end Mental thygiene. In the Martial thygiene. If Ham 27 Is marked other than "natural", or Hearly or other treumatic event, The Medical Examine iny or other treumatic event, The Medical Examine. 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 20 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Payroll dept. supervisor Cluett-Peabody Co. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be Charles Thornbury Bertie Whitt 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marvin Maynard (husband) 4275 Arthur Shipley Rd. Westminster MD 21157 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Glen Haven Memorial Park 12/23/99 Glen Burnie MD permit. Page Department of Important: If any Injury or 22. Name and Address of Fecility Haight Funeral Home & Chapel 21. Signeture of Funerel Service Licensee P.O. Box 195 Sykesville MD 21784 nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, rone, cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final CONGESTIVE HEART FAKURE disease or condition resulting in deeth) **Examiner** Due to (or es e consequence of): sician and burial-transit Sequentially list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consequence of): physician s the burial Box 68760, Physician/Medical Due to (or es e consequence of): Records, P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown End Stage PARKINSONS DISEASE à 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? CEROKROVASCULAR ACCIDENTS HYPERTENSION. certificate 1 Yes 2 No 1 ☐ Yes 2 ☑ No Division of Vital Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certifica 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Certification: 5 Pending 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) in by 4 - Homlcide Certifying Phyeician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) and menner es steted.

2 Wedical Examiner: On the besis of exemination and/or investigation, in my opinion, death occurred et the time, dete end pleca, and due to the cause(s) and menner stated. 29a. Certifiel (Officek o Medical pletaly ck only To the To the To the Complex 29b Signatur 29c. License number 29d. Date signed (Month, Day, Year) D51245 December 20,1999 30. Name and address of parson who completed cause of death (Item 23e) (Type, Print) 200 Memorial Ave., Westminster, MD CONTY SENERAL (DSIII M. M. SHARIF SAJID CARROLL DR 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature State Registrar DEC 2 2 1999

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Deeth Month Physician 27 1999 LOTTIE BELL MCNEIL 7:10 pm December /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LaPlata Civista Medical Center Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Month, Day, Year, OCT 25, 1929 NORTH CAROLINA Months Days Hours 1 M 2 XF 70 237-50-0422 **Usual Residence of Decedent** 10c. City, Town or Location 10s. State 10b. County 10d. Inside City Limits 1 Yes 2 No Director MD CHARLES LAPLATA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ONE MAGNOLIA DRIVE 20646 UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Black, Whita, atc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: P 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE MEDICAL 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 8 MURRY MCNEIL FANNIE (BATTLE) MCNEIL 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KELLY JONES 5195 FAIRFAX HILLS PLACE, INDIAN HEAD, MD 20640 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HUNTT CREMATORY 12/30/99 WALDORF, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligarines

LYDIA C. THORNTON J M00583 22. Name and Address of Fecility
THORNTON FUNERAL HOME, P.A. THORNTON JOHNSON 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Examine placement-Heaters post Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Physician/Medical Due to (or es a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Ď 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 2 💢 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 DUnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certification: 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 1 ElNatural 5 Pending investigation 1 | Yes 2 | No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Place of Injury - At home, term, street, tectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) and manner stated.

The law requires that the death certificate be assouted P.O. Box 68760. Records, Division of Vitai or Attending Physician: ne Hospital or Attanding in 24 hours after deeth. The Funeral Director; After poletely filled in by the fur

Funeral

Director

7 is marked other than "natural", or flams 23s or 28a-f ehow traumstic event, the Medical Examinar must be notified at

2 should be filed within 72 hours after deeth ned Mentel Hyglane. Is marked other than "netural", or forms 23

Pages 1 and 2 should be nent of Health end Mentel I

Department of Health a Important: if Item 27 is any Injury or other tra

Physician /Medical

Examiner

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After

To the Hosp within 24 hos To the Fune completely fi

State Registrar 31. Date filed (Month, Day, Year) DEC 29 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and little of curtified

Nirmaladevi Gurusamy, MD

32. Registrar's Signature

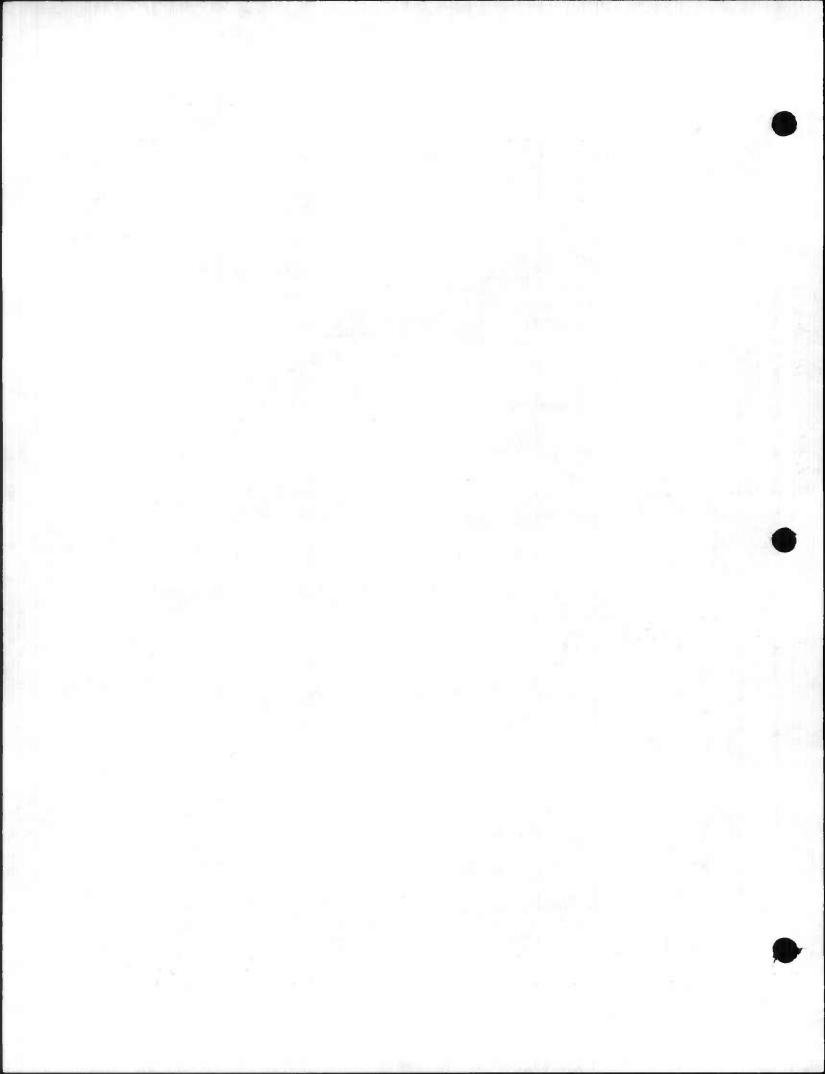
Waldorf, Maryland 20602

29c. License number

1)45737

6 Post Office Road, Suite 103

29d. Date signed (Month, Dey, Year)



Physician /Medical Examiner Box 68760.

Physician

/Medical

Examiner

Directo

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Funeral

Director

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Hygiene.

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Department of Important: If any injury or

filed within 72 hours after

21215-0020

Baltimore, Maryland

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O.

Examiner Sequantially list conditions, if any, laading to immadiate causa. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Be 25. Was casa rafarrad to medical examinar? Certification: To 1 Yas 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 5 Panding Invastigation 1 DiNatural 1 Yes 2 No 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 M Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Cartifian (Check only one) 29b. Signature and 29c. License number

10

0005321

29d. Date signed (Month, Day, Year)

30. Name and addrass of person who completed causa of death (Nem 23a) (Type, Print)
Zafar Amsari, M.D. 8926 Woodyard Rd.#101, Clinton, MD 20735

Registrar

31. Data filed (Month, Day, Year)

DEC 2 2 1999

32. Registrar's Signatura

Bene " hand.

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State of Maryland / Department of Health and Mental Hygiene 9 9 4 1851

					Certi	ficate of	Death		Reg. No.		1001
	1.	Decedent's Name (First, Middle,	Last)					2. Data of De Month	eath Day	Yaar	3. Time of Death
hysician /Medical		Jordan Rob	ert			Massey		Decembe		999	7:54 p.m
xaminer	48	Facility Name (If not institution, g	rive street and number,				4b. City, Town, or L	ocation of Deat	h 4c. County	of Death	
		15109 Bitteroot	Way				Rockville	2	Mont	gomer	У
neral	5.	Social Sacurity Number 6	X	e (In yrs. last bir		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th V Year)	9. Birthple	ica (State or Foreig
ector	-	77-10-9335	10M 2LF	34	Yrs.	Days	110013	May 22	, 1915	Philad	ielphia, P
ž		Da. Stata 10b. County		10c. City, Tow	n or Local	tion				10	d. Inside City Limit
5 6	Ms	aryland Montgom	orv	Rockv	1110						1 ☐ Yes 2X N
ec 589	10	De. Street and Number	<u> </u>	ROCKV	1110	10f. Zip Code			10g. Citizen of \	What Countr	v?
# 23	1	15109 Bitteroot	12. Was Decedent	Ever in IIS	13 We	20853		pecify Vec or No	United	States e - America	
er, or tems 23s or 28s-fs Exerciner must be notified by Funeral Director	•	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowad 4 ☒ Divorced	Armed Forces	No		es, specify Cub	dispanic Origin? (Span, Mexican, Puerto Specify:	Rican, etc.)		ok, White, a	tc.
ted te		15. Decedent's		16a.	Deceden	it's Usual Occup	pation during most of world)	e la a	16b. Kind of B	usinass/Indu	ustry
t, the Magical I		(Specify only highest (Secondary (0-12)	Coilege (1-4or	5+)	life. DO	NOT use retire	d)	ang			
E E		12	oonogo (* voi	,	Cont	ractor			Constru	ction	
event.		7. Father's Name (First, Middle, La	st)				18. Mother's Nan	e (First, Middle	, Maiden Suman	ne)	
To E	7	Thomas Walker Ma	ssey				Florence		Wil	de	
E L		9a. Informent's Name/Relationship	(Type, Print)	196	. Mailing	Address (Street	and Number or Ru	ral Route Numb	er, City or Town,	State, Zip (Code)
trei trei	Γ	Dana E. Martin	(Daughter) 150)9 Bi	tteroot	Way, Ro	kville.	MD	20853	
etto	20	Da. Method of Disposition		20b. Piace o		ion (Name of tory or other pla		Date	20c. Location -		m, Stata
Department of Health and Mental Hygiane. Important: if Item 27 is marked other than naturel, or items 23s or 23s-f show important: if Item 27 is marked other than naturel careful and important in the indifficient intervention once. To Be Completed by Funeral Director		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special	cify)		eake	Cremat	ory, Inc.		Beltsv Maryla	nd	
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dician dical niner	di	nmediate Cause (Final isaase or condition ssulting in death)	e. <u>Metast</u>	atic Ade						7	Veeks
ng physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflieted events										
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Sun and Sunday

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Nama (First, Middle, Last) Month Day Year December 22, 1999 **Physician** Maye Dixon Murphy 8:00 a.m. /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's | Months | Days | Hours | Min. | April 17, 1908 | Min. | Min. | April 17, 1908 | Min. | Birthplace (Stata or Foraign
Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Months 1 M 2 X F Yrs. 220-42-4113 91 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Prince George's Maryland 1 ☐ Yas 2 ☑ No Hyattsville Directo 10a. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6717 Darby Road 20784 U.S.A. Funeral 12. Was Decedant Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Maxican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 ☑ No Specify: White þ 3 Ø Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) 16e Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) College (1-4or 5+) Eiementery/Secondary (0-12) Assistant Administrator Federal Government 1 1 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) George Dixon Dorothy Chaconas 19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Intormant's Nama/Relationship (Type, Print) 8303 Colesville Road Apt. 193, Silver Spring, MD 20910 Jean E. Barnes - Sister 20b. Placa of Disposition (Name of camatary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ₺ Burial 2 □ Cramation 3 □ Ramoval from State Gate of Heaven Cemetery 12/24/99 Silver Spring, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama end Addrass of Facility
Gasch's Funeral Home 21. Signatura of Funaral Sarvice Licansas 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Intarval Batween Onsat and Death Massive GIT bleeding Immediata Causa (Finel disaasa or condition rasulting in daath) Perforated gastroducdenal Wice, Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disaasa or injury that infliated evants resulting In death) Last Dua to (or as a consequanca of) Part II. Other eignificent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Pancreatitis þ 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa referred to medical examiner? Be 26. Place of Daath (Check only one) Hospital: 1 ☑ inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 10 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 27. Manerer of Daath 28c. injury at Work? Certification: Neturel 5 Pending investigation 1 TYas 2 No 2 Accident 28f. Location (Straat and Number or Rural Routa Number, City or Town, Steta) 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, straat, factory, offica building, atc. (Specify) 4 Homleida Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the cause(s) end manner es steted.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature end title of certifiar 29c. License number 43662 30. Neme and address of person who completed causa of daath (Itam 23a) (Type, Print) Drive, Chourty Mrs 20785

To the Hospital or Attention:
within 24 hours after death.
To the Funeral Director: After this ce

Funeral

Director

28a-f ahow

?? is marked other than "natural", or thems 23a or 28a-f shot traumstic event, the Medical Express, must be notified as

pemit. Pages 1 and 2 should be filed within 72 hours effer deeth v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a any injury or other traumatic event, the Medical Example mass.

Physician

/Medical

Examiner

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the signed by t

been s

certificate has

Physician:

The law requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

with the Maryland

Registrar

WilhAm BOLIGE

DEC 2 3 1999

31. Data filed (Month, Day, Year)

PG HOSP

33 Registrar's Signature

300/ Hors

power of force

25 2 3 339

State

Completely filled in Medical Call

Joseph Pestaner,

29b. Signature and title of cartifier

30. Name and a

32. Registrar's Signature

dress of person who completed ceuse of death (Item 23a) (Type, Print)

M.D.

& Sporks

29c. License number

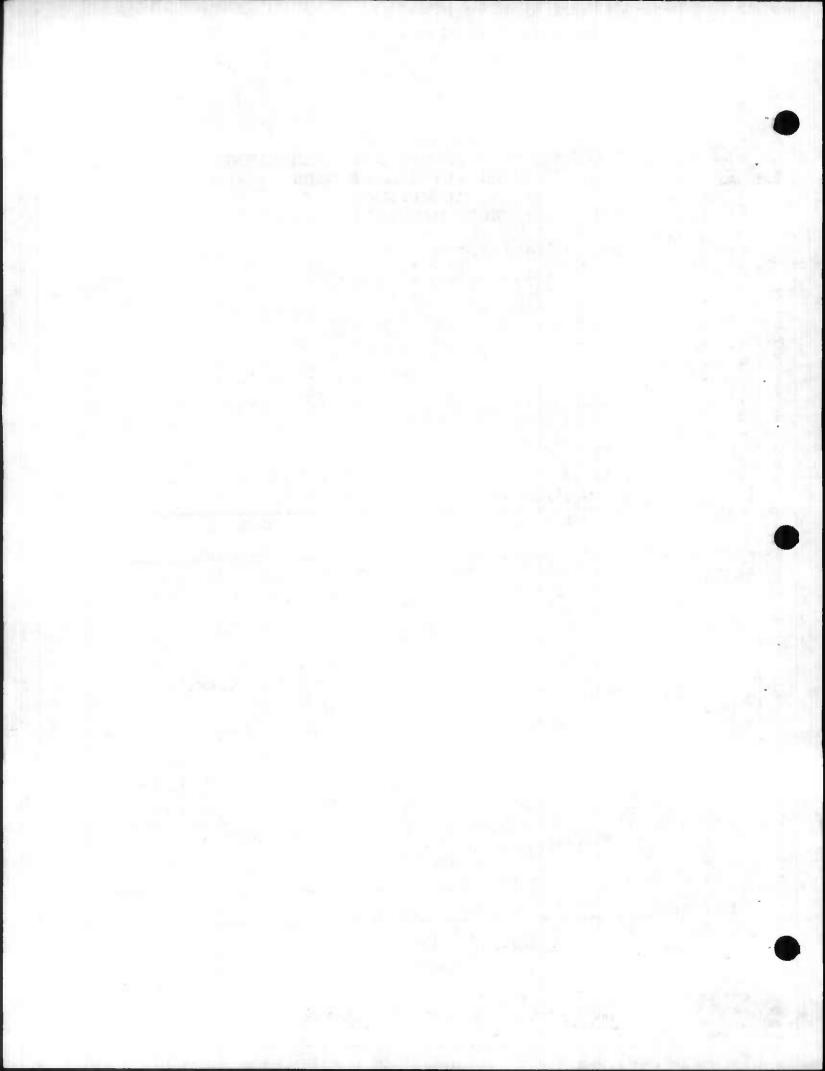
O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

29d. Date signed (Month, Day, Year)

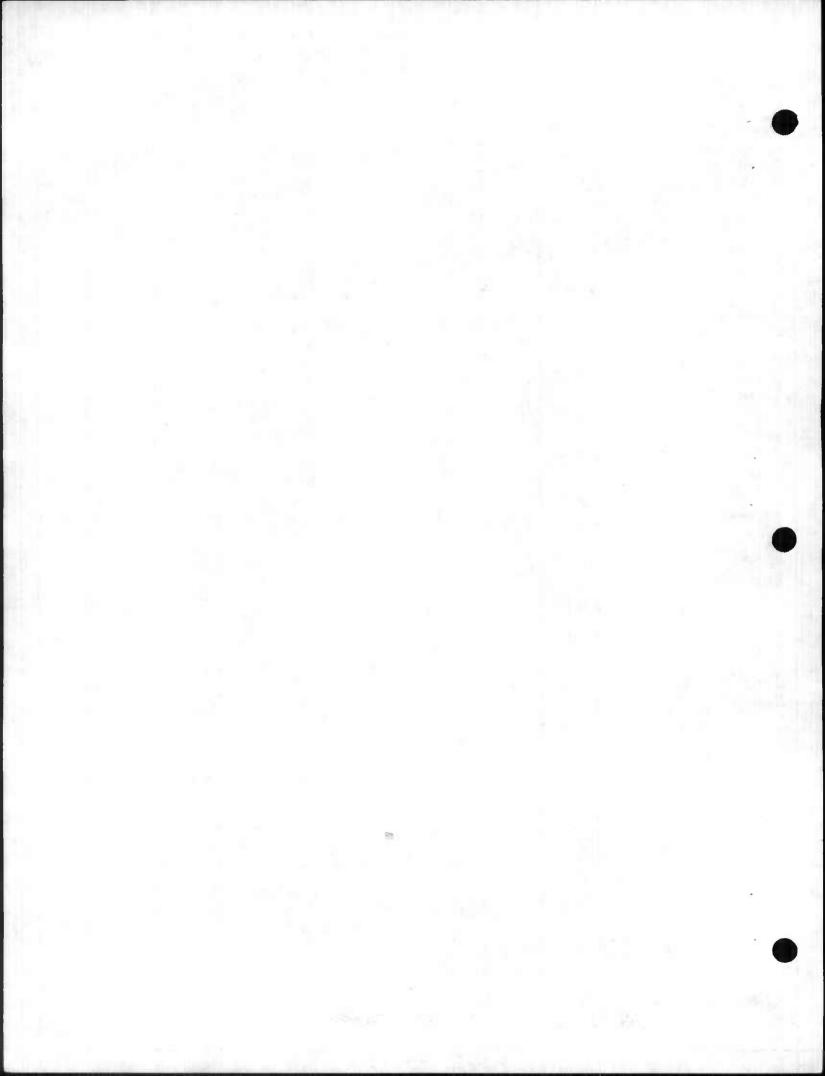
December 24, 1999

DHMH 16 Rev 6/95



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Certificate of Death						Ĭ	

					Cer	tificat	e of L	Death			Reg. No.		
		ne (First, Middle, L						2. Date of Deeth Month Dey Yeer			3. Time of Death		
Physician /Medical	Larry	Edward	Mille	r, Sr.						DEC.	29, 199		11:51 A
Examiner	OR COLUMN	(If not Institution, gi					4		wn, or LO	ocation of Dea OWN		ty of Deeth	NOI
Funeral Director	5. Social Security 232-98-		Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. last 40	birthday) Yrs.	If Under Months	1 Yeer Days	If Under Hours	24 Hrs. Min.	8. Date of B	irth Pey, Year) -59	9. Birth	plece (Stete or Foreigntry) Gan
2	Usuat Residence of	10b. County		10c. City, To	own or Lo	cetion							10d. Inside City Limi
r 28a-f show incritised at	WV	Morga	n	Berke		Spr		S					1□Yes 2ᢂN
r here 23s or 28s-f show finer must be notified at Funeral Director	Rt. 6,	Box 12	090			10f. Zip	254	11			U.S.		ntry?
or he amine	11. Meritel Status 1 Never Mar	ried 2 Married 4 □ Divorced	Armed F	2 No		Was Deced f Yes, aped		ispanic Orl in, Mexicar Specify:	gin? (Sp n, Puerto	ecity Yes or N Rican, etc.)	Bla	ica - Americack, White,	etc.
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Be est	Ray Edward Miller 19a Informant's Name/Relationship (Type Print) 19b Meiling Address (Street end Number of R										e, Maiden Sume		
t of Haaith and Mer if item 27 is marks or other traumatic	Ray Edward Miller Mary Spi										ber, City or Town	n, Stete, Zij Lngs,	WV 2541
Department of Health important: If them 27 is eny injury or other tra		sposition Cremation 3 l 5 Qther (Spec		State Mt.	tery, cren	netory or o	ther plea	tery	1 1	Date 1 - 2 - 0 (20c. Location Berke		own, State Springs
Department important: eny injury poce.		uneral Service Liqu		1							ral Hon		ngs,WV
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been shoul											is an autopsy formed?	e ₁	Vere autopsy finding vailable prior to ompletion of cause f deeth?
oage 2										1 🔀	Yes 2□No	1	Yes 2□ No
s certificata ha director, page	25. Was case refe examiner?	rred to medical					lai		e of Dea	th (Check only	one)		
2 2 2	YEXYes 2					nt 3□ DC	_	4 114	ursing He		sidence 6 🗆 O		ify)
a fra C	27. Manner of Des 1 Netural 2 Accident	5 Pending investigetion	on 12-2	9-99	tnjury	AM		yat k? Yes 2□	No	fell out o		et on a	
as Direct led in by							281. Location City or T	(Street and Nur own, State) Syl	noer or Hui ler Valle Md	rei Route Nymber, ny Norka			
to the regulate or weens within 24 hours after death. To the Funeral Director: A completaly filled in by the fu Medical Certificati	29e. Certifier (Check only one)	1 Certifying P	eminer: On the b	a best of my knowled pasis of examination oner ataled.	dge, deeth and/or in	occurred vestigation	et the tin , in my o	ne, dete er pinion, des	nd ptece, ath occur	and due to the	ceuse(s) and res, date end place	manner es e, end due	stated. to the cause(s)
Withir Comp	29b. Signeture en	d title of cartifier	J. Chut	tieno		29		e number C.M.E	3		29d. Date sign		, Day, Year) 1999
3	30. Name and edd	iress of person who	71	se of death (Item 23			eet,	Balt	imo	re, Mar	yland 2	1201	
State Registrar	31. Date fited (Mo	nth, Day, Year)	32,1	Registrar's Signature	4	hoo	Ks						



Please Ty

ype or Print in Black Indelible ink. Assure All Copies Are Legible.	○ lm lm
State of Maryland / Department of Health and Mental Hygiene 99	855
Cartificate of Death	

	Otato of Mil	Certificate of	Dooth	Reg. No.		
Physician /Medical	1. Decedent's Neme (First, Middle, Last) Kyle Stephen McAu.	Ley	2. Date of Dea Month December	Day Year		
Examiner	4a Facility Name (If not institution, give street end number) Prince George's Hosp	nital Center	4b. City, Town, or Location of Deeth Cheverly	4c. County of Death Prince George's		
Funeral Director	5. Social Security Number 6. Sex 7. Age 1 M 2 F 7.	o (In yrs. last birthday) Yrs. If Under 1 Yea Months Days	r If Under 24 Hrs. 8. Dete of Birth Hours Min. (Month, Da)			
Maryland of show fied at	Usual Residence of Decedent 10a. Stete 10b. County MD Charles	10c. City, Town or Location Waldorf	7 12 10	10d. Inside City Limits 1 ☐ Yes 2 ☒ No		
or death with the Maryla thems 23a or 23a-f show ther must be notified at tuneral Director	10e. Street and Number 320 Pin Oak Drive	101. Zip Code 2060		10g. Citizen of What Country? USA		
020 or all	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent I Armed Forces? 1 Yes 2 Never Married If Yes, Give Year or Dates:		Hispanic Origin? (Specify Yes or No- ban, Mexican, Puerto Rican, etc.) Specify:	14. Race - American Indien, Black, White, etc. Specify: White		
1 21215-0020 ed within 72 hours at yopiens. Acer than "natural", or at, the Medical Exam Completed by I	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usual Occi (Give kind of work don	pation e during most of working ed)	16b. Kind of Business/Industry		
within within the Man	Elementary/Secondery (0-12) College (1-4or 5 2	+) Manager		Video Store		
	17. Fether's Name (First, Middle, Last)		18. Mother's Name (First, Middle,			
Maryland 42 should be file th and Mental Hy 7 is marked oth treumstic event	Kenneth McAuley, Sr.		Annie J. Culp			
_ C G to b	19a. Informant's Neme/Relationship (Type, Print) Kenneth McAuley, Sr Fath	ner P.O. Box 44	et end Number or Rural Route Number Hardyville, VA	23070		
altimore mit. Pages 1: 4 partment of He portant: if Hem y Injury or oths	20e. Method of Disposition 1 ☐ Burial 2 ☒ Cremetion 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Neme of cemetery, cremetory or other pi		20c. Location - City or Town, State Alexandria, VA		
Balt permit Depart Importu	21. Signatury of Funeral Service Licensee		ress of Facility Faulkner Funeral 228 Saluda, VA	Home 23149		
Set Medical Examiner as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	Thrombo	osis		
that the death cert ed by the attending detached for use a	Part II. Other significant conditions contributing to death be	it not resulting in the underlying cause o		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Munknown		
The law requires that The law requires that The law seen signed be page 2 should be deter			24e. Was perfo	an autopsy med? 24b. Were eutopsy findings available prior to completion of cause of death?		
= F 80 0	25. Was case referred to medical		1 🖫 1	/es 2 No 1127Yes 2 No		
Of Vital Physician: T	examiner?	nt 2 XER/Outpatient 3 DOA	ther: 4 Nursing Home 5 Resid			
or Attending Physics of Attending Physics of Attention Street or After the in by the funeral striff cation: 1	27. Manner of Death 1 Natural 5 Pending (Month, Day 2 Accident Investigation	Year) Injury W	ury at ork? 28d. Describe I	now injury occurred		
Division of attending P as after death. The division of the true of the p the funers Certification:	3 Suicide 6 Could not be determined 28e. Place of Injuried building, etc	ury - At home, farm, street, fectory, offic (Specify)	e 28f. Location (S City or Tox	Street end Number or Rurel Route Number, vn, State)		
Hospi 24 hou Funer Funer stely fill	29a. Certifier (Check only one) 1 Certifying Physician: To the best of end manner ste	examination and/or investigation, in my	time, date and plece, end due to the opinion, death occurred at the time,	cause(s) and manner as stated. dete and place, and due to the cause(s)		
To the comple	290. Signature and Allie of certifier tare	11/10	o.C.M.E.	29d. Date signed (Month, Day, Year) December 25, 1999		
Le	30. Name and address of person who completed cause of d	eath (Item 23a) (Type, Print)		re, Maryland 21201		
. State Registrar		ar's Signeture				

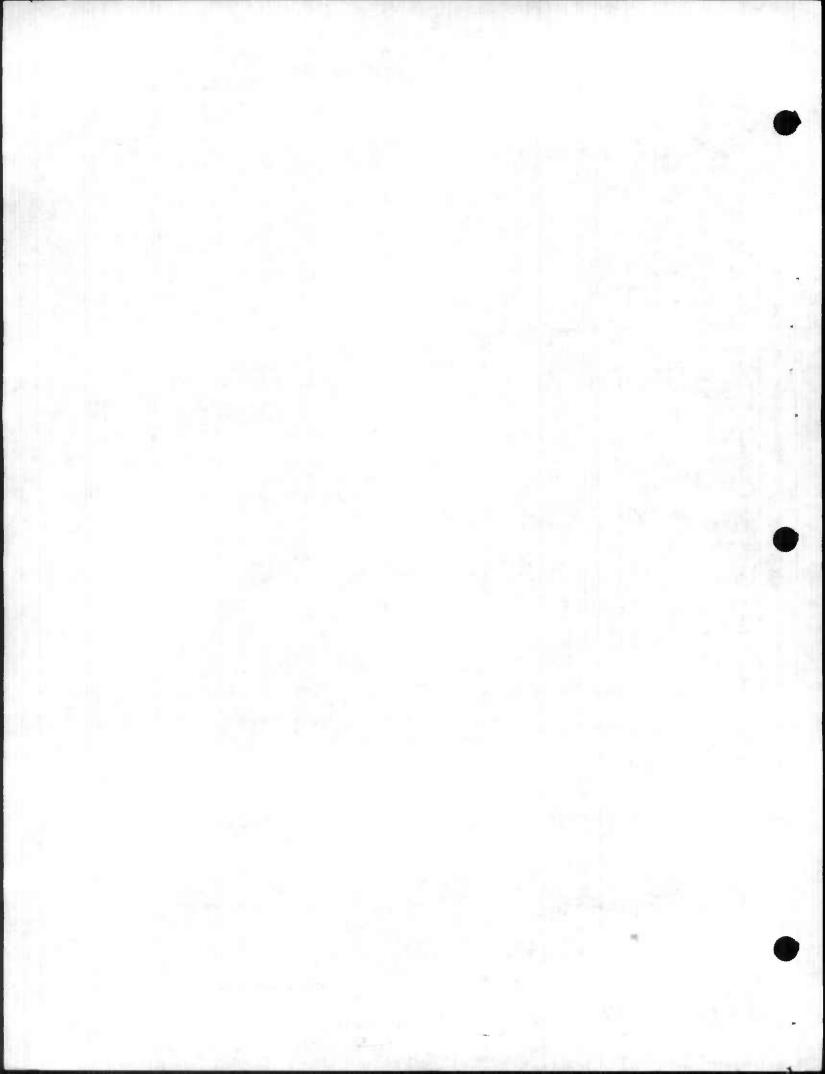
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Registrar **DHMH 16 Rev 6/95**

JAN 06 2000

32. Registrar's Signature

ORIGINAL



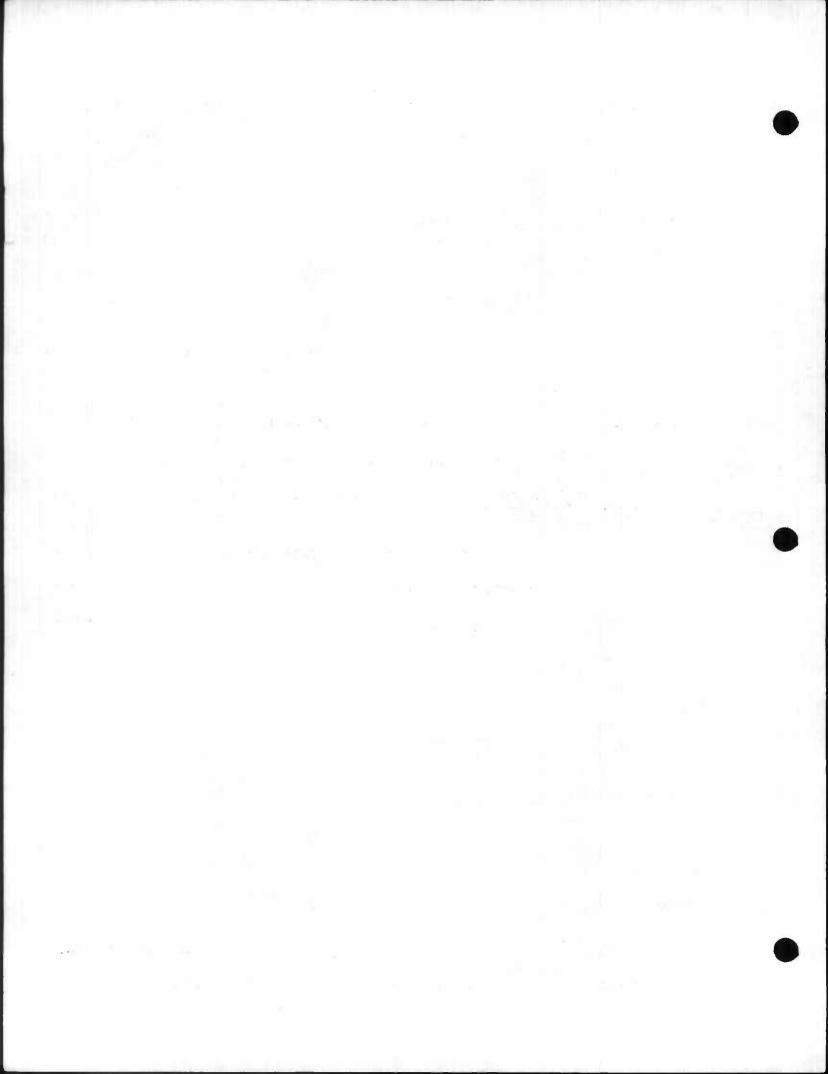
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Department of Health a important if them 27 is any injury or other tree office.	Eileen M. Nato	li,	Wife		1730	5 Mos	s Si	de La	ne,	Olney,	, MD	20832		
	20a. Method of Disposition				Place of Disp	osition (Ne	eme of	e)	D	Date	20c. Location	on - City or T	Town, State	
	1 Burial 2 □ Cramation 3 □ Ramoval from State Cematary, crematory or other place) Dec 21,												ng. MD	
	Gate of Heaven Cemetery 1999 Silver S 21. Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Facility DeVol Funeral													
	23a. Partl. Enter the disection or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one ceuse on each line.													
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DENNIS FRIEDMAN, M.D., 31. Data filed (Month, Day, Year) DEC 2 1 1999

15225 SHADY GROVE ROAD, SUITE #201 ROCKVILLE,



Registrar

31. Data filed (Month, Day, Year) DEC 23 1999 32. Registrar's Signatura Denewa

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

James M. Salander, M.D.

oaks

11119 Rockville Pike, Rockville, MD 20852

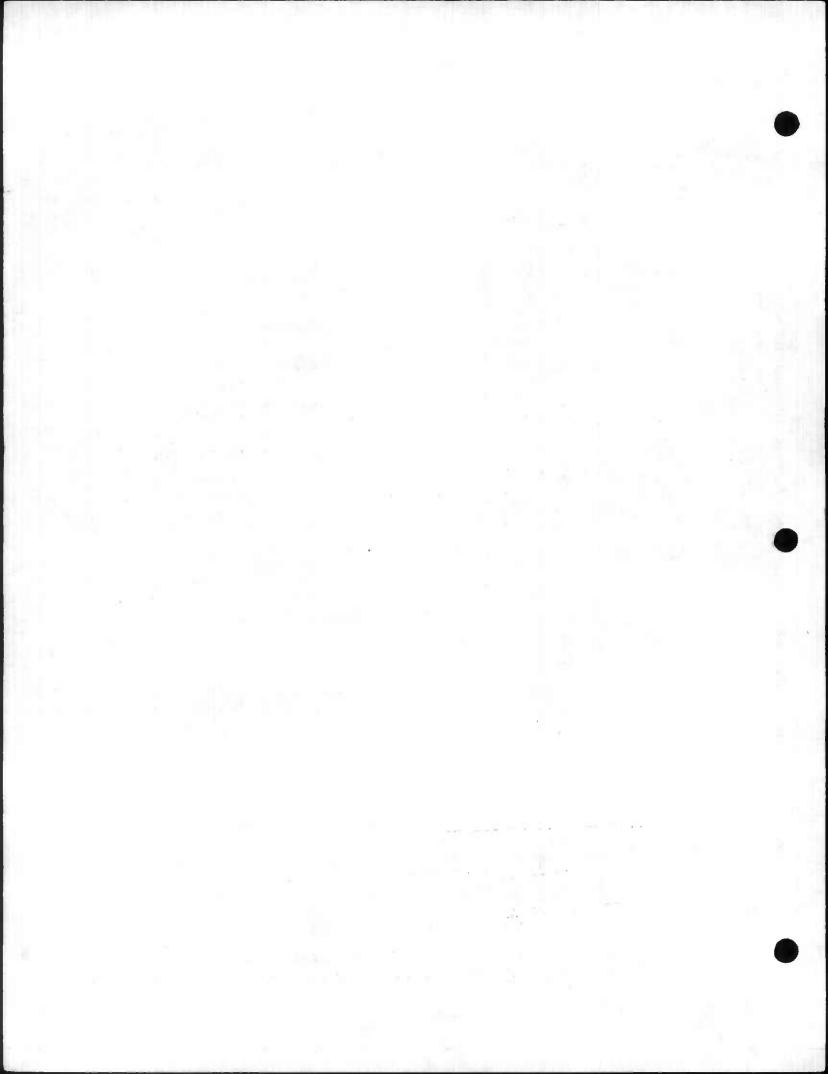
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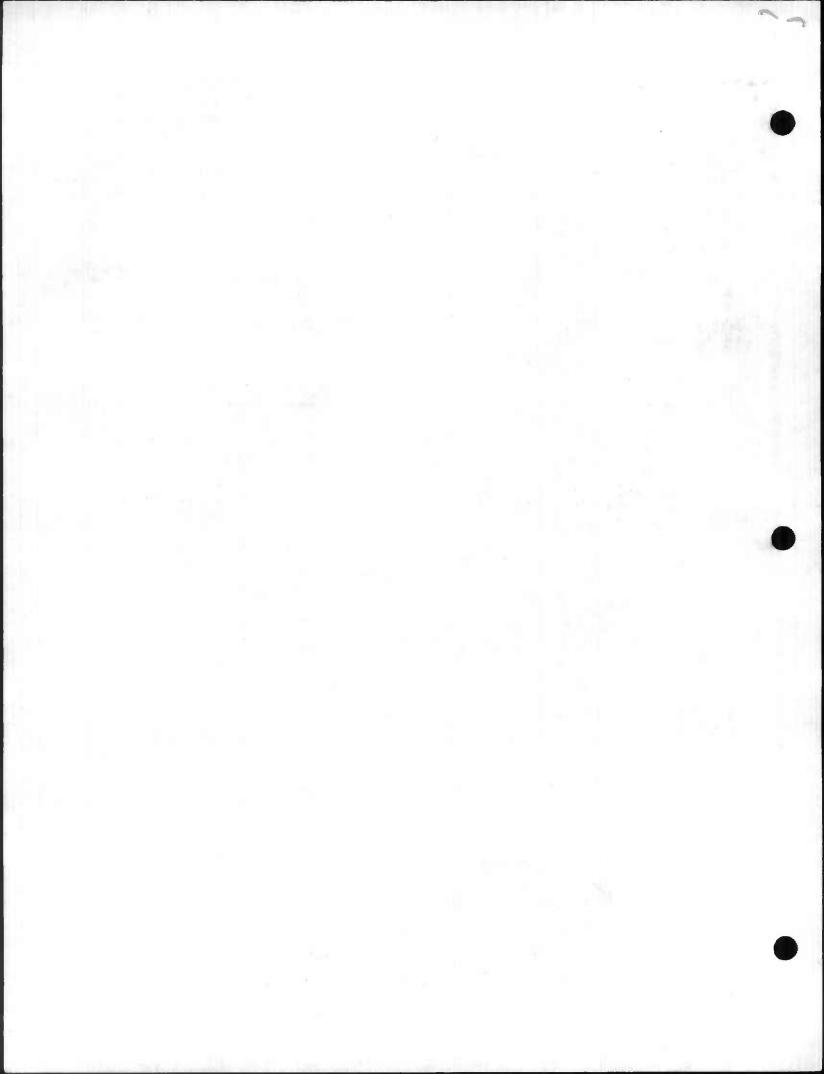
Division



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 9 Mont Co Certificate of Death 12/20/99, per M.D., 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death DECEMBER 16, **Physician** 1999 ADEEB NEAM JACK 2345 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CALVERT MEMORIAL HOSPITAL PRINCE FREDERICK CALVERT If Under 1 Yeer | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 1X M 2 □ F 578-05-8854 Yrs. 83 Director JAN.17,1916 WASH D.C Usual Residence of Decedent r 28a-f show 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits Y Yes 2 No Directo MD CALVERT CHESAPEAKE BEACH 10s Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 5 na 23a c 3813 BAYVIEW DRIVE 20732 USA Funeral Neme Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Meritel Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or the any Injury or other traumatic event, the Marical Fernance. 1 (X) Yes 2 No 1 9 4 2 - Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WHITE Specify: þ 3 Widowed 4 Divorced 1943 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED SALES 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) NICHOLAS NEAM ZAKIA SHADID 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) LOUISE NEAM/ WIFE 3813 BAYVIEW DR. CHESAPEAKE BEACH, MD 20732 20b. Piaca of Disposition (Name of 20c. Location - City or Town, State 20e. Method of Disposition cametery, crematory or other place) 1 ☑ Buriai 2 ☐ Cremetion 3 ☐ Removel from State 12/21/99 BRENTWOOD, MD. FT.LINCOLN 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Juneral Service Licenses 22. Name and Address of Facility PHILIP 11818 P D.RINALDI FUNERAL SERVICE NEW HAMPSHIRE AVE.SILVER SPRING, MD markey 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceusa on each line. Approximate Interval Between Onset and Death **Physician** Few month /Medical Recurrent Immediate Cause (Finai disease or condition resulting in death) Examiner Due to (or as a consequence of): Non Hodgkin's Lymphoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yss 2 No 3 Probably 4 Unknown Failure Dlane geslive Records, Completed by ate has been signe 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Melliter 2 1) nabele Dlypoth 1 Yes 2 TNo 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of or Attending 5 Pending 1 Naturat e Hospital or Attending n 24 hours after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Piaca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner es stated.
2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical within 24 ho To the Funcompletely 1 (Check only one) 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 nund. Allend D19427 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) ANWAR T. MUNSHI, M.D., PRINCE FREDERICK, MD 20678 31. Dete filed (Month, Dey, Year)
DEC 2 0 32. Registrar's Signeture State 1999

DHMH 16 Rev 6/95

Registrar



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					Certific	ate of	Death		Reg. No	0.	Life 1	000
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Physi /Med		VERA	S.	ľ	NEESE			Decem			,1999	8:30
Exam		4e. Fecility Name (If not institution, give	street end number)				4b. City, Town, or I			c. County		
		13015 7th. St	reet				Bowie			Pri	nce G	eorge's
。 Funera Directo		5. Social Security Number 6. Security Number 213-38-3088 Usual Residence of Decedent	9x 7. Age □ M 2 🗓 F	e (in yrs. iast 74	Yrs. If Un Monti	der 1 Year hs Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, De Aug. 3	h y, Year	,		e (Stete or Foreign
dend dend		10a. Stata 10b. County		10c. City, T	own or Location						10d.	Inside City Limits
the Many 28a-f sh outfied	Director	Maryland Prince	George'	s Bov		#/ # TV						1 X Yes 2 No
with a or					10t.	Zip Code					Vhat Country	
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21215-0020 d within 72 hours after death with the Marylend giene. In than "netural", or items 23a or 28a-f show it han "netural", or items 23a or 28a-f show it ha Medical Examiner must be notified at	by Funeral	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	111		pecify Cub	Hispanic Origin? (S) an, Mexican, Puert Specify:	o Rican, etc.)			k, White, etc.	
5-0	Completed	15. Decedent's Edi		1	6a. Decedent's U	sual Occup	pation	tula a	16b. F	Kind of Bu	siness/Indust	
within within the wind	nple	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NO	T use retire	during most of word)	king				
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be filed that Hygie d other	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nan			n Sumem	e)	
arylan should be nd Mental marked o	ို	Ernest Bannowsl	су				Ott	ilie Ko	nig			
Maryiand Id 2 should be file Ith end Mental Hy It Is marked other traumatic event		19a. Informant's Name/Relationship (T					end Number or Ru					de)
		Wilbert A. Nees	e / Husb	T								
Page:		20a. Method of Disposition **CPBurial 2 Cremation 3 I 4 Donation 5 Other (Specify,		ceme	etery, crematory of	or other ple	co) Dec. 2 emetery o				City or Town, Mary 1a	
Departition of the control of the co	MIN	21. Signature of Funeral Service Licens	" Rich	0,	Rober	t E.	Evans Fu					r
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ilcetions that caused	the death. D	Do not enter the m	Anna	polis Rd	or respiratory ar	Mar rest,	ylan	Ap	proximete
Physician		snock, or neart failure. List only o	ne cause on each lin									erval Between set end Death
/Medica		Immediate Cause (Final disease or condition	Char	1	myelos	inor	o Leu	Cania) VCC
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that the deeth ceed by the ettendid	Physician/	Part II. Other significant conditions con	ntributing to death bu	t not resulting	g in the underlyin	g cause giv	ven in Part I.			yse con	tribute to the	cause of death?
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slcla carti	o Be	examiner?	Hospital:		0.1-1/ 0.00	Oth	28. Place of Dea			. 50.		
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ding it.	tlor	Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Dey	Year)	Injury M	28c. Injur Wor	rk? Yes 2 □ No		,-	,		
the Hospital or Attending Physician: Tha is the Hospital or Attending Physician: Tha is the Zunerel Director. After this cardificata he mpletaly filled in by the funeral director, page	Certification:	3 Sulcide 6 Could not be determined	28e. Piaca of Inju building, etc.	ry - At home, (Specify)	, farm, street, fact	ory, offica		28f. Location (S City or Tow	Street as m, Stet	nd Numbe	or Rurel Ro	oute Number,
To the Hospital	edical C	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	alcian: To the best of ner: On the basis of	examination:	lge, death occurre and/or Investigati	ed at the tir	ne, date and place, pinion, death occur	, and due to the c	cause(s	and mai	nner as stated	d. cause(s)
thin the	Mec	29b. Signature and title of contines	and manner stat			29c. Licens	e number		29d Da	ite signed	(Month, Dey	Year)
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(10)		30. Name and address of person who co	empleted cause of de	ath (Item 23s	a) (Type, Print)	4.	1 / 3 8 1 W. hls	ich	1-	D	- 7 1	210
		31. Date filed (Month, Day Year)	32 Pagister	r's Signature	MAG	IN	n. 114	1/19/	(I)	UK	- 70	30
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death **Physician** 2:16 /Medical 4a Facility Nama (If not intitution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE'S CLINTON If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) MAY 25, 1926 9. Birthplaca (Stata or Foraign Country) Charlottesville 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 10 M 2NF 73 230-20-1975 Yrs. Director Usual Basidence of Decedant permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental hygiene.
Important: if item 27 is marked other than "natural", or itema 23a or 28e-f show any injury or other transmitten oversit, makedisal Examinar mast he notitied as 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits MORNINGSIDE PRINCE GEORGE'S 1 Yas 2 No MARYLAND Director 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 4512 ALLIES RD. 20746 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 11 Marital Status 14. Race - Amarican Indian, Black, White, atc. 1 Nevar Married 2 Married I ☐ Yas 2 ☑ No Baltimore, Maryland 21215-0020 1 Yas 2 No WHITE Specify: Specify: þ 3 Widowed 4 □ Divorced Yaar or Datas Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 5 t h College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Surnama) Be LULA LUE DOWELL HEZI MELTON 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19e. Informant's Neme/Ralationship (Type, Print) DAUGHTER MORNINGSIDE , MARYLAND 20746 HELEN NICHOLS/ 4512 ALLIES RD. 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from State WASHINGTON NATIONAL CEM. 12-20-99 SUITLAND, MD 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility MARSHALL S FUNERAL HOME OF MD 21. Signature of Funaral Sarvice Licensee Suitland, MD 20746 4308 Suitland Rd. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Approximata** Intarval Batwe Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Examiner pr as a consequence of). Physician/Medical Examiner monysema physicien and the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Diseese or injury that initiated evants rasulting in death) Last Box 68760, Dua to (or as a consequance of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Cigorettes 12 Yes 2 No 3 Probably 4 Unknown Division of VItal Records. þ 24b. Ware eutopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? page 2 should Be Completed 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physicien: within 24 hours after deeth.

To the Funeral Diractor: After this certifics completely filled in by the luneral director. hours after deeth. uneral Director: After this certific by filled in by the luneral director, 25. Was case referred to medical 26. Placa of Death (Check only one) Hospitel: 1 Inpatient 1 Yas 3€ No Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending invastigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be 3 Suicide 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 | Homicide 1 Certifying Physician: To tha best of my knowledge, deeth occurred at tha time, dete end plece, end due to tha cause(s) and menner as stated.

| Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Data signed (Month, Day, Year) 29b. Signatura and 29c. Licansa number DW ed causa of death (ftem 23a) (Type, Print) HVR 7700 31. Data filed (Month, Day, Year)
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CHIADIKOBI OSUCHUKWU

State of Maryland / Department of Health and Mental Hygiene
3 PART I. 27 Certificate of Death

Reg. No.

WK.	2 2
Reg. No.	

AMEND ITEMS: #23 PART I. 1. Decedent's Name (First, Middle, Last)
Chiadikobi Osuchukwu 2. Date of Death 3. Time of Death Day 30, 1999 **Physician** DECEMBER 4:03P.M. /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner LAUREL REGIONAL HOSPITAL LAUREL PRINCE GEORGES 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** 110 M 2□ F Months Deys Hours Min 31 Yrs Unknown Director Nigeria Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince Georges Md. Beltsville 1 Ves 2 No Director 28a-f: the Medical Examiner must be notifi-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? flams 23a or 12179 Beltsville Drive 20705 Nigeria Funeral 12. Was Decedent Ever In U.S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: b Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiens. should be filed within Elementary/Secondary (0-12) College (1-4or 5+) Science & Technology 5+ Manager 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be id Mental marked o Chief Emmanuel U. Osuchukwu Gladys Ntiejum 10 D.E. 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Pages 1 and 2 s mant of Health an int of Health i 12179 Beltsville Dr. Emmanuel O. Osuchukwu (Brother) Beltsville, Md. 20705 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20a Method of Disposition Dete 01-12-00 Akabo, Ikeduru, Imo Nigeria 1 N Burial 2 □ Cremation 3 □ Removal from Stete ò permit. Page Department of Important: If any Injury or 2002 Family Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility W. H. BACON FUNERAL Home, Inc. 3447 14th St., N. W. Washington, D. Wandle Bacon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in deeth) CARDIAC ARRHYTHMIA **Examiner** Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and Due to (or es e consequence of) Box 68760. attending physician for use as the buria Due to (or as e consequence of) use as the 23b. Did tobacco use contribute to the cause of death? P.O. ate has been signed by the page 2 should be detached Part II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown of Vital Records. Completed by 24b. Were autopsy findings available prior to 24a. Was en eutopsy performed? completion of cause of death? 2□No 1 Yes 2 No this certificate septal or Attending Physician: The hours after death.
Ineral Director: After this certificate by filled in by the funeral director, pa Be 25. Was case referred to medical 26. Piace of Death (Check only one) Hospital: 1 ☐ Inpatient 2XX €R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1º 1 XYes 2 □ No 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Naturel Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours all To the Funeral D completely filled is Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) and menner as stated (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end titte of certifie O.C.M.E. **DECEMBER 31, 1999** 30. Neme and address of person who completed ceuse of deeth (Item 23a) (Type, Print) TITUS MiD JACK m. 111 Penn Street, Baltimore, Maryland 21201

DHMH 16 Rev 6/95

State

Registrar

31. Dete filed (Month, Dey, Year)

JAN 0 3 2000

32. Registrer's Signeture

244

Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Tima of Death December 17, 1999 **Physician** Thomas Bobby Price 8:14 pm /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick FREDERICK 8. Date of Birth (Month, Dey, Year) NOV. 20, 1943 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Virginia 5. Sociel Security Number **Funeral** Deys 100M 20 F 225-52-8310 56 Yrs Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠ Yas 2 No Frederick Directo MD Mt. Airy 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23s or 12310 Sherwood Forest Drive 21771 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, etc.) Marra 12. Was Decedent Ever in U,S. Armed Forcas? 14. Race - Amarican Indian, Bleck, White, atc. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: 62-68 filed within 72 hours after 1 Never Merried 2 Married 6 Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grede completed) U.S. Parcel Elementery/Secondery (0-12) College (1-4or 5+) 2 yrs Deliveryman Service 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 is marked o any injury or other traumatic eve Floyd I. Price Martha R. Valentine 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21771

Forcet Dr. Mt. Airy, MD 19e. Informent's Neme/Relationship (Type, Print) Maureen V. Price (Wife) 20b. Plece of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Burial 2 ☐ Crametion 3 ☐ Ramovel from Steta Lincoln Park Cem. 12/23/99 4 ☐ Donetion 5 ☐ Other (Specify) Rockville, MD 21. Signature of Funeral Service Lightsee 22. Name end Address of Fecility SNOWDEN FUNERAL HOME, P.A. nourdly 20850 ROCKVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediete Ceuse (Final diseese or condition resulting in deeth) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Couse (Disease or Injury that Initioted events resulting In death) Last Due to (or es e consequenca of): Box 68760. Physician/Medical the Due to (or es e consequence of): 88 signed by the atte Pert II. Other significant conditions contributing to daeth but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown allure on Dialysis Division of Vital Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical axaminer?
1 ☐ Yes 25 No Be 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpetient 2 ER/Outpetient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? After Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifian 29c. License number 10 30. Neme and address of pe on who completed cause of death (Item 23a) (Type, Print) 172 THO MUT ITCHNSON DRIVE, FREDERICK, MID 21702 32. Registrer's Signeture JEHNSON

DHMH 16 Rev 6/95

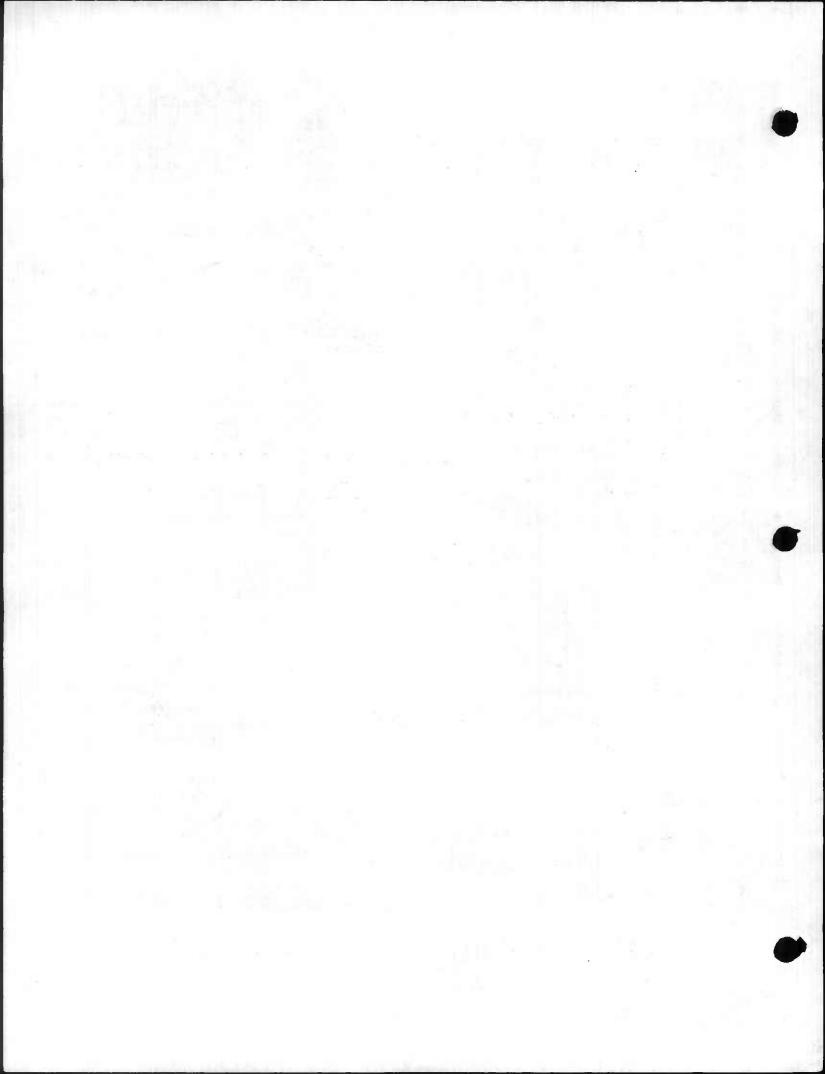
State

Registrar

31. Dete filed (Month, Day, Year)

DEC 2

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** December 16, 1999 10:39 A.M. Edward Clark Prettyman /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner ROCKVILLE SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hra. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State of Birth (Month, Day, Year) | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | 1935 | Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1⊠M 2□ F Director 577-46-1130 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limita worle Pages 1 and 2 should be filed within 72 hours effer deeth with the Maryle nent of Health and Mentel Hyglene.

ent: if Item 27 is marked other than "natural", or Items 23s or 28s-f show ury or other treumstic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland Montgomery Rockville 10g. Citizen of What Country? 10f. Zio Code 10e. Street and Number 20850 United States 318 W. Montgomery Avenue Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yea, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1957-1 ⊠ Yes 2 □ No If Yas, Give Year or Dates: 1 Never Married 2 Married 21215-0020 Specify: White 1 Yea 2 No Specify: P 1960 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Electrical Engineer Maryland 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Dorothy Clark Charles Wesley Prettyman 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant'a Name/Relationship (Type, Print) 318 W. Montgomery Avenue, Rockville, Maryland 20850 Maureen Prettyman/Wife altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 18, Department of Important: If eny Injury or page. Montgomery Crematorium, Inc. 1999 Bethesda, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Fecility Robert A. Pumphrey Funeral Home/Rockville, Inc. ill & Donen M00672 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or conditio resulting in death) Examiner Dua to (or as a consequence of) Examine N FREDROWT W physician end s the buriel-transit the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Acesta TRECUME FACK ORE Physician/Medical Due to (or es a consequence of): P.O. signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. ò 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? pege 2 s 1 Yes 2 No 1 Yes 2 XNo of Vital 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital:

Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division Attending Natural 5 Pending investigation a effector: After 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, Iarm, street, lactory, office building, etc. (Specify) 4 ☐ Homicide e Hospital or A 24 hours effer Funeral Directions pietely filled in b CHI Certifying Physiciae: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical To the Hosp within 24 ho To the Fune completely fi er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30+1 H51780 December 17, 1999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

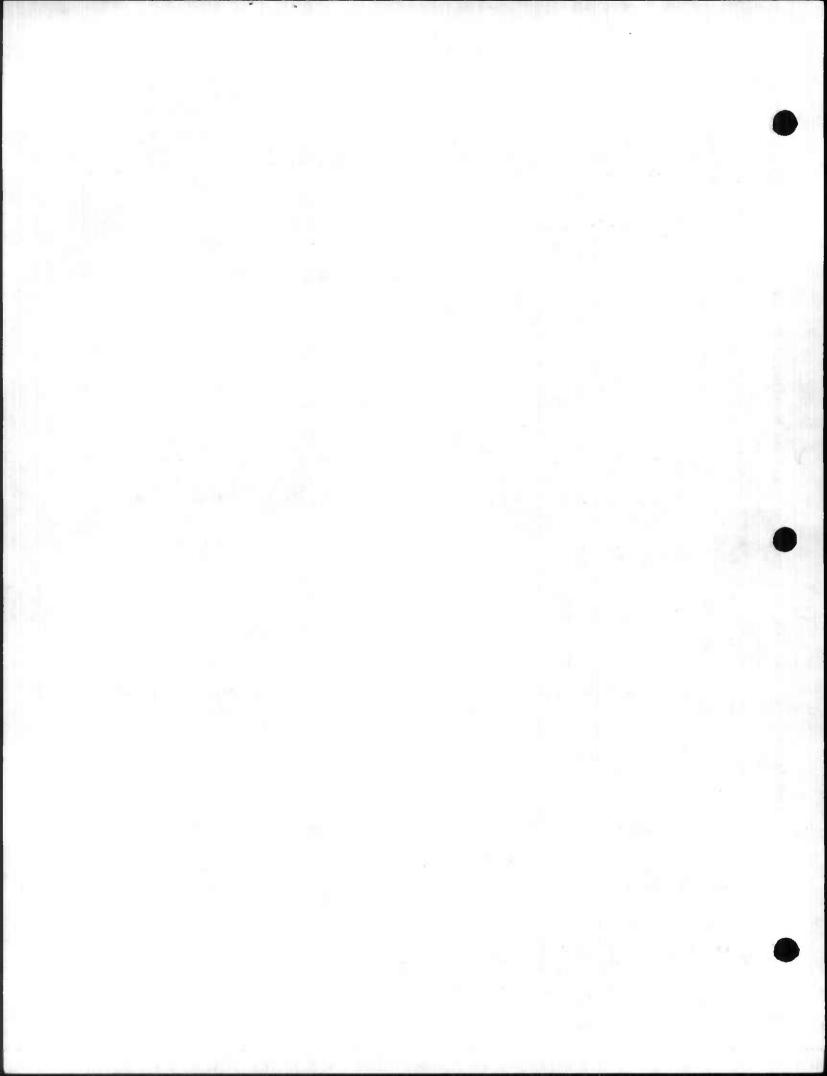
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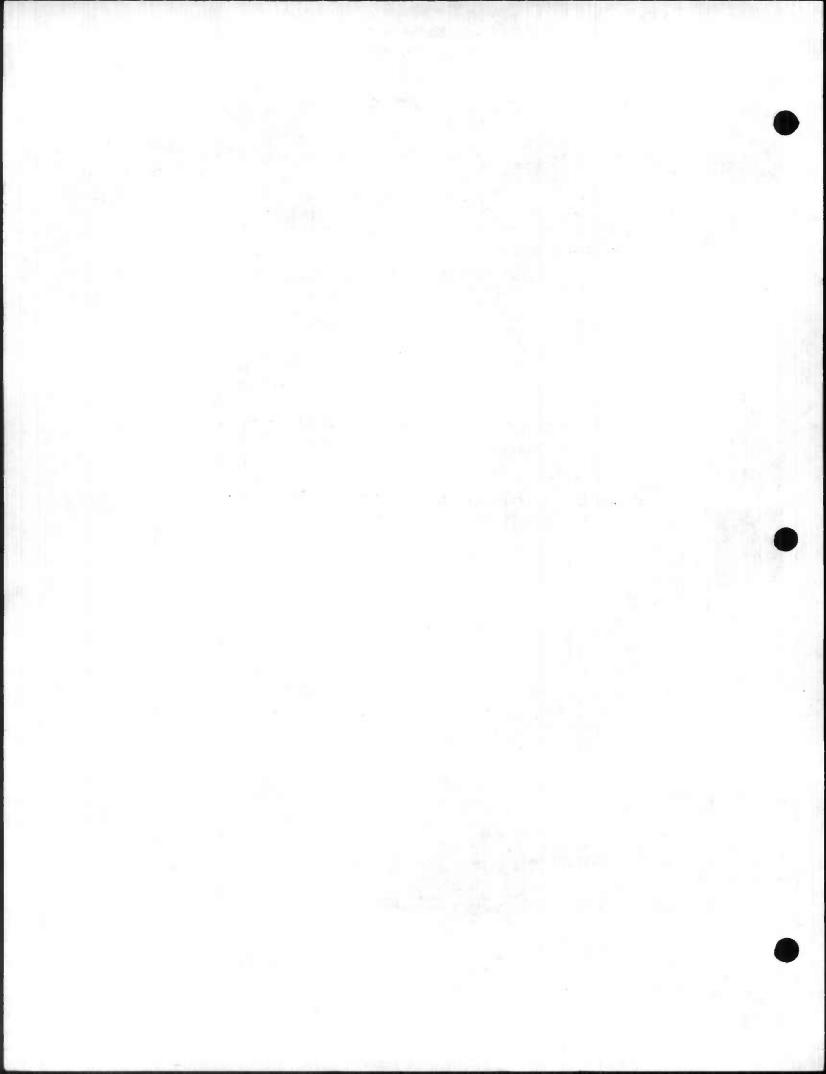
State of Maryland / Department of Health and Mental Hygiene 99 41866

				Ce	rtificat	e of	Death		R	eg. No.	6	4100	0
hueician	1. Decedent's Name (First, Mide	de, Last)		1100				2	Date of Deat		Year	3. Time of	Death
hysician /Medical	CATHERINE	CARTER	1	PR	ESCOT	T		D		19 19	999	11:10	A.M.
aminer	4a Facility Name (If not institution		ber)				4b. City, To	wn, or Loca	ition of Death	4c. County	of Death		
	SUBURBAN H				If Under	1 7000	BETH If Under	4.11			GOMER		
ral or	5. Social Security Number 217–48–3663 Usual Residence of Decedent	6. Sex 1 □ M 2 🗷 F	7. Age (In yrs. last 96	Yrs.	Months	Days		Min.	Dale of Birth (Month, Day, EB. 28,	Year)		place (State on try) ORGIA	r Foreign
by Funeral Director	10a. State 10b. Count	у	10c. City, T	own or Lo	ocalion						1	I0d. Inside Cit	ty Limits
Director	MD MONTGOMERY CHEVY C					HASE		0- 05	1⊠ Yes 2 No				
								20815			0g. Citizen of What Country? U. S. A.		
by Funeral	11. Marital Status 1 Never Married 2 Ma 3 TWidowed 4 Divorce	rried 1 Yes 2	2 📆 No		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue □ Yes 2 ☑ No Specify:			n, Puerto Ric	fy Yes or No- can, etc.)		ck, White,	can Indian, etc. WHITE	
Completed		nt's Education est grade completed)	1		dent's Usua kind of wo		pation during mos	at of working		16b. Kind of B	usiness/în	dustry	-4
1dr	Elementery/Secondary (0-12)	College (1-	4or 5+)	lite.	DO NOT us	se retire	ed)						
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8	17. Father's Name (First, Middle EDGAR CARTER							And a second		Maiden Suman	ne)		
2									RINE RO				
	19a. Informent's Name/Relation CARTER PERRY	eship (<i>Type, Phint)</i> — DAUGHTER								, City or Town			
	20a. Method of Disposition	DAUGHTER			ELROSI osition (Ner		KEET	-	Y CHASE	20c. Location	2081		
Į.	1 🗱 Burlal 2 Cremation 4 Donation 5 Other (tate	etery, cre	matory or o	ther pla				ROCKVI			AND
	21. Signature of Funeral Service	E, Hon	enbake							LER'S S		0016	
Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. STUFFUL TOURE URSTRUCTION Due to (or as a consequence of):												
by Physician/	Part II. Other significant condit	ions contributing to dea	ith but not resultin	in the u	underlying c	ause gi	iven in Part I	i.	23b. Did to	bacco use co	ontribute to	o the cause (of death?
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Completed b									24a. Was a perform		av	ere autopsy fi vailable prior to empletion of co death?	0
E									1 🗆 Ye	es 2 No	1[Yes 2	No
Bec	25. Was case referred to medic	al					26. Place	e of Death (Check only on	18)	1		
To B	examiner?	Hospitel: 1 XIIn	patient 2 ER	/Outpatie	nt 3 DC	Ot A	her			ence 6 Ott	her (Specif	(y)	
	27. Manner of Death	28a. Date of		b. Time o	e of 28c. In		iry at	28	d. Describe ho	ow injury occur	rred	THE	
Certification:	2 Accident inves	2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office							2 No 281. Location (Street and Number or Rural Route Number, City or Town, Stete)				
edical C	29a. Certifier (Check only one) 1 Certify 2 Medica	ng Physician: To the b Examiner: On the bas and manne	is of examination	dge, deat and/or in	h occurred evestigation	at the ti	ime, date an opinion, dea	nd place, and ath occurred	d due to the ca at the time, d	ause(s) end m ate end place,	anner as s and due to	tated. o the cause(s	;)
₹ .	29b. Signature and title of certifi	er			290	. Licen	se number		2	9d. Date signe	ed (Month,	Day, Year)	
)	Merlyn	Uomi	w nus)	(03	579	1		12/19/	99		
)	30. Name and address of person	who completed cause	of Seath (Item 23	la) (Type,	Prima		Cur	TE 2	27.(JUVEI	250	ZING	
tate	31. Date filed (Month, Day, Year		gistrar's Signature	9		-				MOZ	2090	37	
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Registrar

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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Shirley Theresa Popejoy 7:53 AM December 18, 1999 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Desth Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Yeer | If Under 24 Hrs. 7. Aga (In vrs. last birthday) Birthplaca (State or Foreign Country) 8. Data of Birth (Month, Day, Year) Months Days 1□ M 2 F Hours 578-22-1980 75 November 9, 1924 Virginia Usual Residence of Deceden 10a. Stata 10b. Counts 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland | Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8616 Hempstead Avenue 20817 United States 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11 Marital Status Black, White, atc. 1 ☐ Yes 2 ☒ No If Yas, Give Year or Dates: 1 ☐ Never Married 2 ☐ Merried 1 Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 M Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Court Reporter Federal Government 18. Mothar's Nama (First, Middle, Maiden Sumema) 17. Father's Name (First, Middle, Last) Harvey Jackson Pearl Elizabeth Ferrior 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sybil M. Hopkins/Daughter 1128 8th Street, N., Fargo, North Dakota 58102 20s. Method of Disposition 20b. Place of Disposition (Nama of cematary, cremetory or other plece) 20c. Location - City or Town, Steta Data December 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 22, 1999 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 22. Name and Address of Fecility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 21. Signature of Funefal Service Licens M00846 23a. Part / Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximata Intarvat Batween Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Cardiac Arrest Due to (or ss s consequence of): Pulmonary Emboli Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Nonknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 Yas 2 No 25. Was case referred to medicat axaminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28b. Tima of Injury 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 X Natural

Examine physician and the burlei-transit 68760. Physician/Medical Box 985 P.O. Records, þ Completed irector, page 2 si 0753 Division of Vital 8 Certification: To this Affer deeth.

SHIRLEY

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Physician

/Medical

Examiner

Funeral

Director

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Funeral

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Completed

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72 hours after

Baltimore, Maryland 21215-0020

be filed within 72 hours after nat Hygiens. d other than "natural", or the event, the Medical Examin

permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Nem 27 is married othe any Infury or other trainmade event, obtas.

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State Registrar

31. Date filed (Month, Day, Year) DEC 2 1999

Edward F. Aulisi,

6 Could not be detarmined

2 ☐ Accident

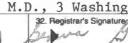
3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of centifier



30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

3 Washington Circle #306, Washington, D.C. oaks

1 🔯 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end dua to tha causa(s) end menner as stated.

29c. License number

D0043921

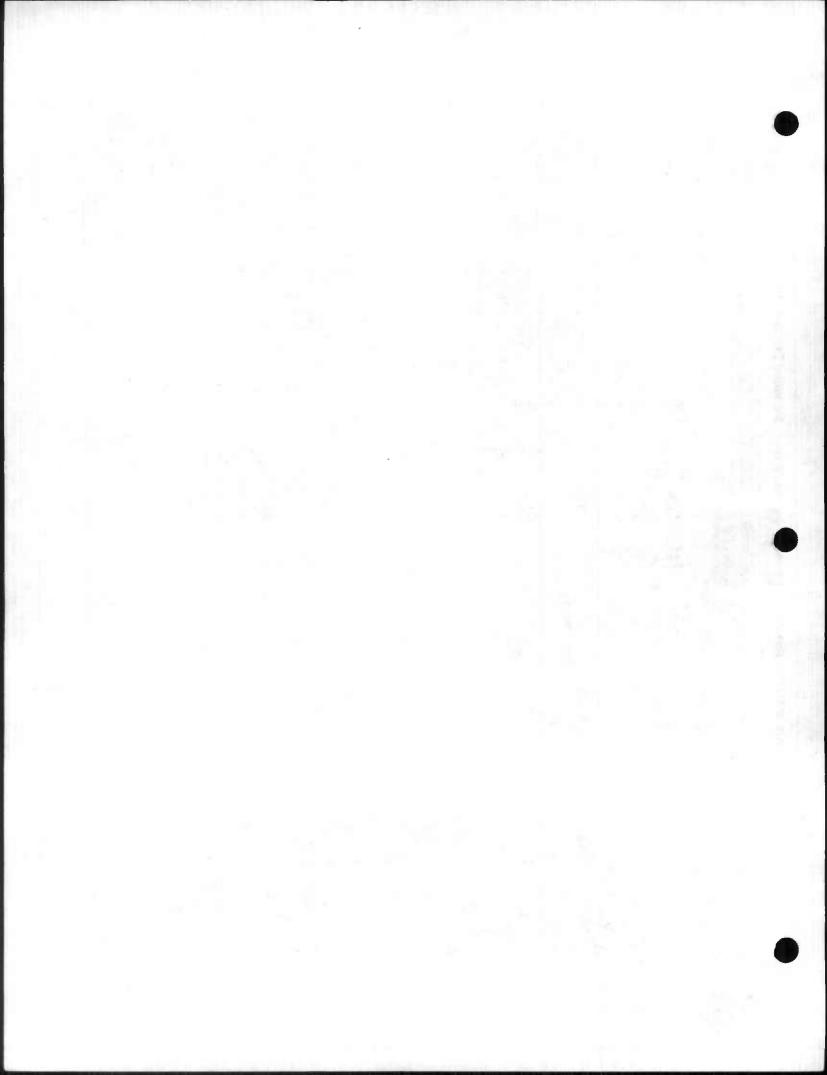
1 Yas 2 No

ner: On the basis of axaminetton and/or investigation, in my opinion, death occurred at the time, deta end plece, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29d. Data signed (Month, Day, Year) December 19, 1999

20037-2381



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** PICAZO 2:34 AM JOAQUIN K 17/999 4c. County of Death DECEMBER /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL MONTGOMERY ROCKVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 217-68-8154 1922 Director Jan. 18, Cuba Usual Residence of Decedent the Manyland permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Menlei Hyglene. Important: if item 27 is marked other than "natural", or fram 23s or 28s-f show eny injury or other traumatic event, the Medical Examination must be notified at editors. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 1235 Potomac Valley Rd. 20850 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 11 Yes 2□ No Specify: Cuban Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assembler Electronics 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 8 0 Daniel Picazo Eloisa Gomez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Monroe St., Apt. 1204, Rockville, MD 20850 Modesta Picazo/ Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dec. 23, Comfort Crematory Alexandria, VA 4 Donation 1999 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 6 monthis Examiner Examiner physicien and s the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of): been signed by the ettending should be detached for use as Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown Records, þ Completed 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death? page 2 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital or Attending Physicien: funeral director, 8 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) After 5 Pending investigation 1 Natural To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fi death. 1 Yes 2 No 2 Accident 6 ☐ Could not be determined 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 Homicide 29a. Cartifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

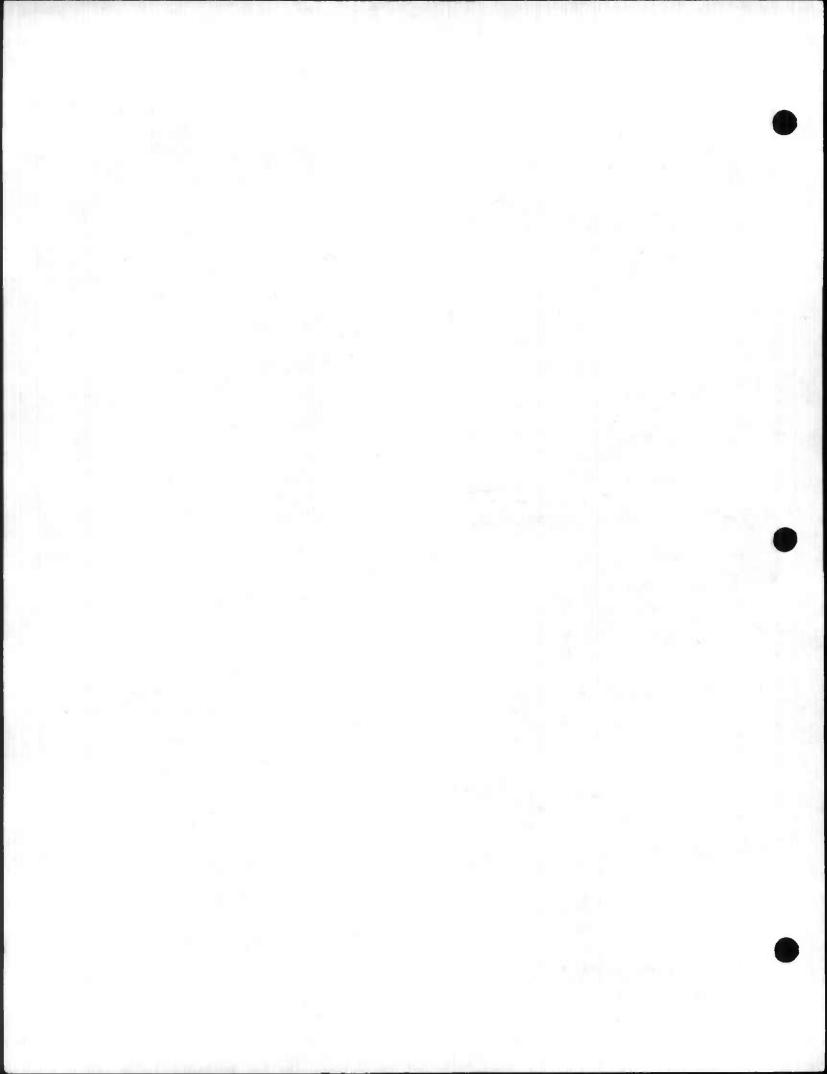
| Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier-29d. Date signed (Month, Day, Year) 29c. License number December 17 1999 D37891

State Registrar 31. Date filed (Month, Day, Year) DEC 20



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
A RAJVAN SHI MD | 21 Congression of

Ln #409 Rockille MD-20152



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** rer lath 1206 YSONIA 12 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita DINEU MD Montgomery montgomer Genera If Under 24 Hrs. 7. Aga (In yrs. last birthday) 9 Birthplace (State or Foreign Country) 6 Sex 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 20 F Months Days Hours Min 73 29, 1926 Director 129-46-8099 Greece Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylei Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified. 1 ☐ Yes 2 No Directo Maryland Montgomery Olney 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20832 4721 Brightwood Road USA 2. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☐ XNo If Yes, Giva Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 Yes 2 XNo Specify: White Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fathar's Name (First, Middle, Last) 2 Marika Rombokou John Papadopoulos 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 4721 Brightwood Road, Olney, MD Aousonio Perlatti / Husband 20832 20b. Place of Disposition (Name of cematery, cramatory or other place) Date 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven Cemetery 12/22/99 Silver Spring, MD 22. Name and Address of Facility 21. Signature of Fureral Service Licensee Francis J. Collins Funeral Home, Inc. 500 UNiversity Blvd., W, Silver Spring, MD20901 enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Batween Onset and Death 23a Part1. Enter the diseas on fications that ceused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the one cause on each line. Physic_≀an 15 M'Nuta /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner physician end the burial-transit Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last certificata be Physician/Medicai CARCINOMA 80 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 'ericArdiA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 € Unknown signed t þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed page 2 has 20 No 1 ☐ Yes 2 ☐ No. 1 TYes Attending Physician: funeral director, 25. Was cese referred medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how Injury occurred 27. Manner of Death 28b. Time of After 1 Natural Injury 5 Pending s efter deeth. investigation 1 ☐ Yas 2 ☐ No 2 Accident n 24 hours efter dee he Funeral Director niately filled in by th 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 4 Homicide 6 Hospital 1 Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner stated. 29a. Certifier To the Hosp within 24 hor To the Fune complately fi edical (Check only one)

State Registrar 31. Date filed (Month, Day, Year)

15A12124

29b. Signature and title of certifier

DEC 21

Name and address of person who completed ceuse of death (tem 23a) (Type, Print)

EVIN

32 Registrar's Signature

MA

10215

29c. License number

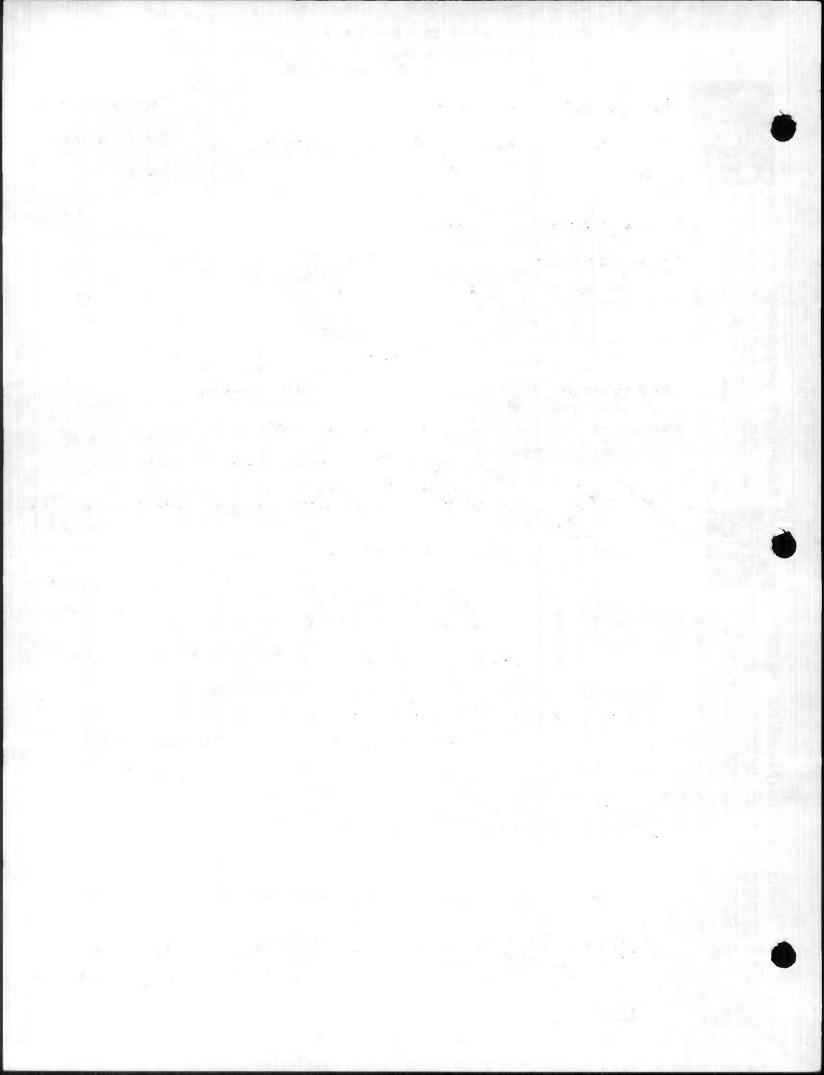
Ferrwood Rd.

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amend item 28a-f State of Maryland / Department of Health and Mental Hygiene per me G850 12-8-05 tas Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death Month **Physician** 19 Wilhelmina 2314 100 /Medical 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Park Advents. Nashington Takoma Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Aga (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (Stete or Foreign **Funeral** Days 1□M 2XF Months Hours 154-30-6134 60 Director September 8,1939 South Carolina Usual Rasidence of Decedant 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits show Maryland Prince George's Hyattsville 1 X Yas 2 ☐ No Director 28m-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 1410 Nicholson Street 20782 U.S.A. flame 23a 12. Was Decedent Ever in U.S. Armed Forcas? 1 ☐ Yes 2 M No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Meritel Status Black, Whita, atc. 72 hours after 1 Nevar Married 2 Merried 21215-0020 ò 1 ☐ Yas 2X No Specify: **Black** à 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest greda complated) Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) Cafeteria Worker Government 12th marked other Baltimore, Maryland 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumema) 1 and 2 should be fill Health and Mental H Ism 27 is marked oth Be James David Champagne Leila Mae Dicks 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Lafayette Porter/Husband 1410 Nicholson Street, Hyattsville, Maryland 20782 Important: If Itam 27 any injury or other tr Pages 1 20b. Place of Disposition (Nama of cematary, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 12/27 b 1 ☐ Burial 2 ☐ Cremetion 3 🖾 Removal from Stata Hillside Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 1999 Sumter, South Carolina 21. Signetura of Funerel Sarvice Licensea 23. Nama and Address of Facility
J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the dispess, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or hearf failure. List only one cause on each line. Approximata Intervat Between Onset and Deeth **Physician** Immediata Causa (Final disaase or condition rasulting in deeth) /Medical Examiner Examiner certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Couse (Diseese or Injury that initiated events resulting in death) Last consequence of): Box 68760 Physician/Medical the Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 3 signed I Records, þ 24b. Wara autopsy findings evailable prior to complation of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 1 ☐ Yas 2 ☐ No Division of Vital or Attanding Physician: 25. Was casa rafarred to medical examiner? Be 26. Place of Death (Check only ona) 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) Certification: To 2ER/Outpatient 3□ DOA 1 Inpatiant this 27. Menner of Deeth 28b. Tima of Injury 28d. Describe how Injury occurred 28a. Dete of Injury (Month, Day Year) 28c. tnjury at Work? 5 Pending invastigation 1 Natural death. 1 ☐ Yes 2X No 12-19-1999 2 Accidant 2115 Subject hanged self after deatl 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1410 Nicholson St. Hyattsville, MD 28a. Plece of Injury - At homa, ferm, street, factory, office building, atc. (Specify) 4 Homlcida filled in home hours a Hospital 24 hours Certifying Physician: To the best of my knowledga, death occurred at tha time, data and place, and dua to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. Medical 29a. Cartifier To the Hosp within 24 hor To the Fune completely fi (Check only 29b. Signature end title of certifle 29c. License number 29d. Data signed (Month, Day, Year) WM DIME 30. Nema and addrass of person who completed cause of death (Item 23a) (Type, Print) 2/0/ metical Park PX IRA N BRECHER, m) DME SISVER SPIN Md 2 31. Date filed (Month, Day, Year) 32 Registrar's Signature DEC 2 1 1999 Registrar

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State of Maryland / Department of Health and Mental Hygiene 9 9 1, 1 9 7 1

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th the	Director	10e. Street end Number				10f.	Zip Code			10g. Citizen of	What Cour	ntry?		
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0 00-	y or other	20e. Method of Disposition 1 🖾 Buriel 2 □ Crem 4 □ Donetion 5 □ Ot			20b. Pleca of I cemetery	Disposition (Neme of or other ple	^{∞e)} Dec. 23	, Dete 1999	20c. Location	- City or To			
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DIVISIO To the Hospital or Attendit within 24 hours after death. To the Funeral Director: At	pletely fill			yaician: To the bes niner: On the besis and menner:	of exemination and		tion, in my o	opinion, deeth occu		date end pleca	, and due to	o the ceuse(s)		
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Willie Pender, Jr. December 18,1999 7:07 P.M. /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Washington Adventist Hospital Montgomery Takoma Park
If Under 24 Hrs.
Hours | Min. | 8. Dete of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex tX M 2 ☐ F If Under 1 Year 8. Dete of Birth (Month, Dey, Year)
December 24,1932 North Carolina 7. Age (In yrs. last birthday) **Funeral** Days Yrs 245-48-8873 66 Director Usual Residence of Decedent the Maryland 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 Yes XXNo Director Maryland Prince Georges Landover Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3901 71st 20784 U.S.A. death Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Meritel Status filed within 72 hours efter of Hygiene. Wher then "natural", or item 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 If Yes, Give Yeer or Detes 1 ☐ Yes 2X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT usa retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Truck Driver permit. Pages 1 and 2 should be filled w.
Department of Health and Mental Hygien, important: If them 27 is marked other tha any Injury or other traumatic. Trucking Company 17. Fether's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Willie Pender, Sr. Linnie Ward 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Helen Pender/Wife 3901 71st Ave. Landover Hills, MD 20784 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stete XXBurial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Lincoln Cemetery December 23,1999 Brentwood, MD 21 September of Funeral Service Licers 22. Neme end Addrass of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd. Brentwood, MD 20722 elaul 23e. Pert1. Enter the disease, or comblications that caused the deeth. Do not enter the mode of dylng, such as cardlec or respiretory errest, shock, or heart all tre. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physiclan** /Medical Immediate Ceusa (Finel CAR DIOPUL MORARY disease or condition resulting in death) Examiner Dua to (or as a consequence of):

ONGESTIVE HEART FAILURE

Due to (or es e consequence of): Examiner thet the death certificate be executed physician end s the buriel-transit Sequentielly list conditions, if eny, laading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that Initiated evants resulting in death) Lest Box 68760. Physician/Medical Due to (or es e conseque 9 P.O. I Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? been signed by t should be detech 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Records, þ Be Completed 24b. Were autopsy findings eveilable prior to 24e. Wes en autopsy performed? complation of ceusa of deeth? page 2 certificate 1 Yes 2 No 1 ☐ Yes 2区 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was case raferred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannar of Death 28a. Dete of Injury (Month, Dev Year) 28b. Time of 28d. Describe how Injury occurred Certification: 28c. injury et Work? 1 Netural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Cartifying Physician: To the bast of my knowledge, deeth occurred at the time, date end piece, and due to the ceusa(s) and manner as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data end piece, and due to the cause(s) end menner stated. Medical 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yaer) DECEMBER 2D 1999 29d. Date signed (Month, Dey, Yaer) MO 30. Nema end address of person who completed cause of deeth (Item 23e) (Type, Print) HAPPOVER PARKUAY GREET BELT MARYLAND 10100 31. Dete filed (Month, Dey, Yaer) State DEC 2 3 1999

Registrar

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June 1. July

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #10c,12/22/99,BMW,Montg.Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Elva **Physician** Reed 1999 20% Dec. 12:30P. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11907 Gordon Avenue Prince George's Beltsville If Under 24 Hrs. 8. Date of Birth Month, Day, Year Sept . 14, 1910 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 N F Months Hours Pennsylvania 89 218-66-6337 Director Usuel Residence of Decedent the Maryland 10e State 10b. County 10c. City. Town or Location worls 10d. Inaide City Limits pernit. Peges 1 and 2 should be filed within 72 hours effer deeth with the Marylei Department of Heelth and Mentel Hygiens. Important: if ferm 27 is marked other than "natural", or hems 23s or 28s-f show the jujury or other treumatic event, the Medical Emerican must be notified as once. Maryland Prince George's -11907 Gordon Avenue Beltsville 1 Yes 2XXVo Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 11907 Gordon Avenue 20705 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forcea? Black, White, etc. 1 ☐ Yes XX No If Yes, Give 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify ò 3XWidowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Kehler Maria Blyler P 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice E. Silbaugh (daughter) 881 Kings Retreat Drive Davidsonville, MD 21035 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XBurial 2 Cremation 3 Removel from State Lincoln Cemetery 12/23/1999 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. on of Funeral Service Lice 4400 Powder Mill Rd. Beltsville, Maryland 20705 omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final da disease or condition resulting in death) Examiner Due to (or as e consequence of) Examiner physician and the burief-transit that the deeth certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting Due to (or es a consequence of) Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of) USB signed by the a d be detached f 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 Yes 2 No à The law requires 24b. Were autopsy lindings available prior to Completed 24a. Waa an autopsy performed? completion of cause of death? page 2 has 1 Yes 2X 100 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work?

Box 68760. P.O. Records, of Vital funeral Certification: Division Attanding n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fi r deeth.

Naturel 5 Pending investigation 2 Accident

3 ☐ Suicide

29b. Signature and titlight certifier

29e. Certifier (Check only

6 Could not be 4 Homicide

28a. Date of Injury (Month, Day Year) 28b. Time of

CUM

1 Tyes 2 TNo 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)

**Exertifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. License numbe D544

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

December 21, 1999

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Bennett So, M.D. 8317 Cherry Lane Laurel, Maryland 20707

State Registrar

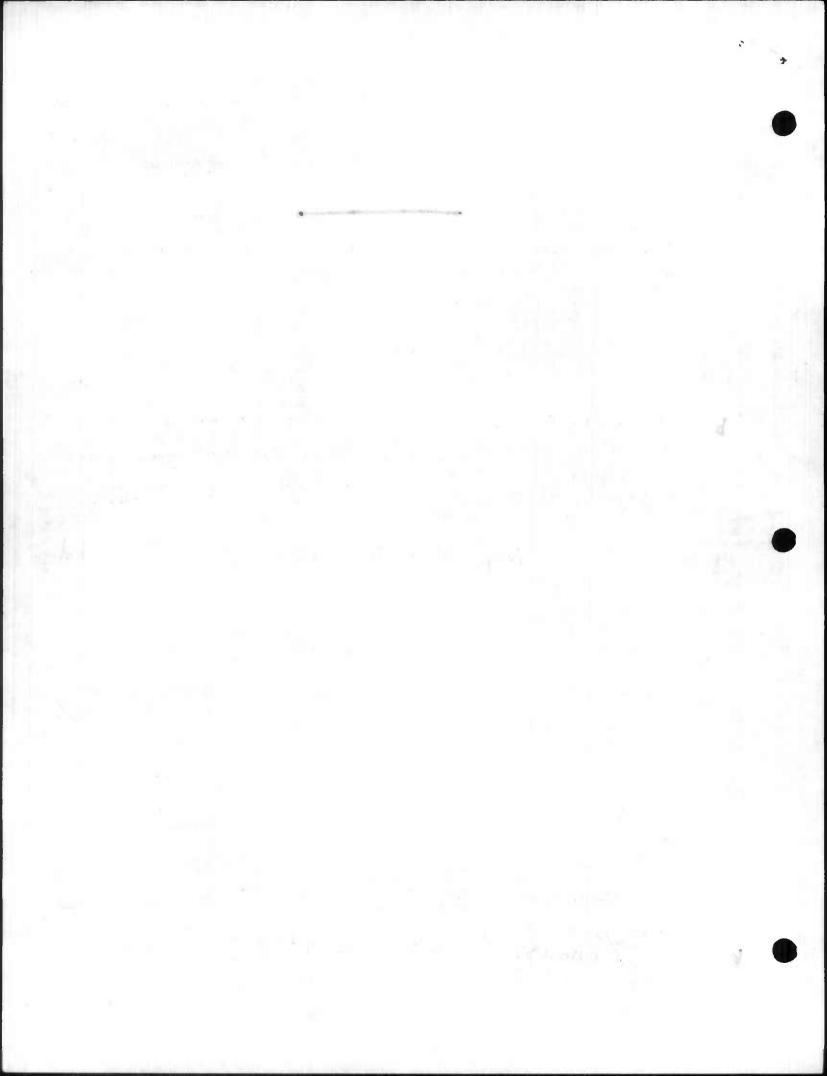
Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature **DEC 22** 1999

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6 Hospital

To the Hosp within 24 hor To the Fune completely fi



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month MOZELL ROGER 12-13-1999 11:18AM 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL CLINTON If Under 24 Hrs. PRINCE GEORGE H Under 1 Vear Data of Birth (Month, Day, Year) 6-30-1957 7. Age (In yrs. last birthday) 9. Birthplace (Stata or Foreign WASH, DC. Months Davs Hours 10M 20F 577-80-8159 42 Yes Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No MD PRINCE GEORGE LANDOVER 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 7326 LANDOVER ROAD APTE 20785 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 ☐ Yas 2X No If Yas, Giva Year or Datas: 1 X Never Married 2 ☐ Married 1 Yas X No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elamentary/Secondery (0-12) College (1-4or 5+) UNEMPLOYED 10TH 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) ROBERT ROGERS SELERY WELLS 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 6152 SPRING HILL TERR. #105 MARYLAND. 20770 ROSEMARY BELL (SISTER) 6152 SPRING HILL TERR. 20b. Place of Disposition (Name of cometary, crematory or other place) FOREST HILLS CEMETERY 12/18/99 MARYLAND 20a. Mathod of Disposition 20c. Location - City or Town, Stata CLINTON, 1 X Burial 2 Cremetion 3 Remove from Stata 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility AUSTIN ROYSTER FUNERAL HOME 3821 14TH STREET N.W., WASH, DC. 20011 21. Signature of Estneral Service Licens or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory errest, List only one cause on each line. Approximata Interval Batween Onset and Death shock, or hear Immediata Causa (Final disaasa or condition rasulting in death) more thus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of). Due to (or es e consequance of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 40 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Was an autopsy performed? 2) No 1 ☐ Yas 1 ☐ Yes 2 ☐ No 25. Was cas 26. Place of Death (Check only one) examinar? 1 Yas 2 No Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA 28b. Tima of 27. Manner of Death 28a. Data of Injury (Month, Day Year) Injury al Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending invastigation 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homicide

The law requires that the death certificate be executed Box 68760. P.O. Records, Division of Vital Physicien: epital or Attending Physical after death.

nerel Director: After this filled in by the funeral di To the Hospital c within 24 hours at To the Funerel D completely filled

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Examiner

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The Medical Examiner must be notified at

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21215-0020

Baltimore, Maryland

State Registrar

DHMH 16 Rev 6/95

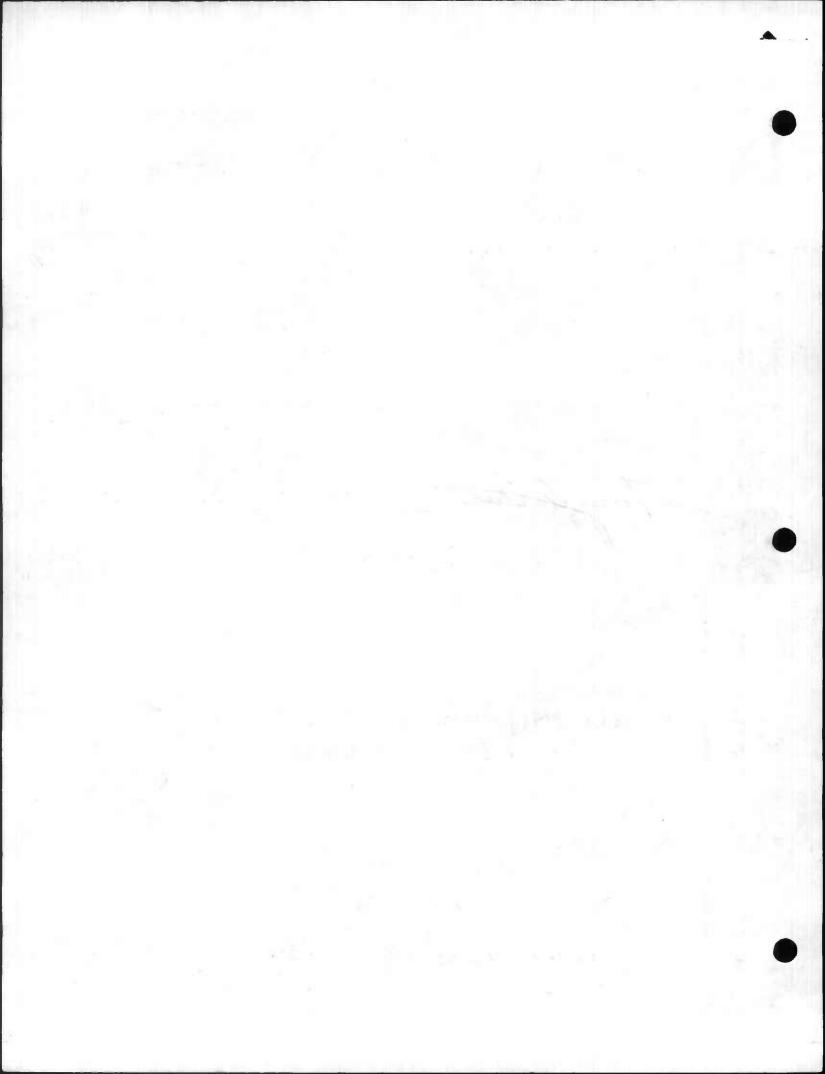
31. Data filed (Month, Day, Year)

30. Nama and addrass of person who completed/causa of death (Item 23a) (Type, Print)

32. Registrar's Signatura

15X Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

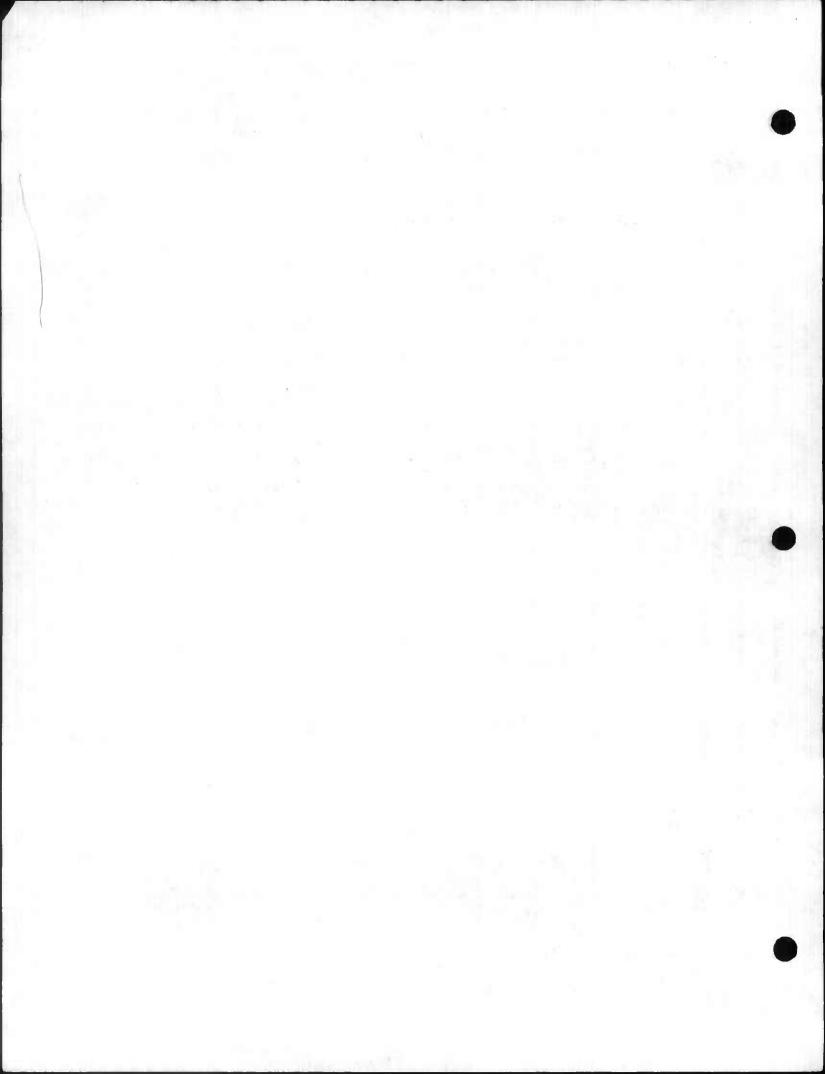
29d. Data signed (Month, Day, Year)



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ineral rector		5. Social Security Number 220-39-4082 Usual Residence of Decedent	S. Sex 7. Age 1 □ M 2 Ž F	6 (In yrs. last bi	rithday) If Under Months		in. (Month, De	8. Dete of Birth (Month, Dey, Year) Oct 23, 1993 9. Birthplace (State or For Country) Maryland				
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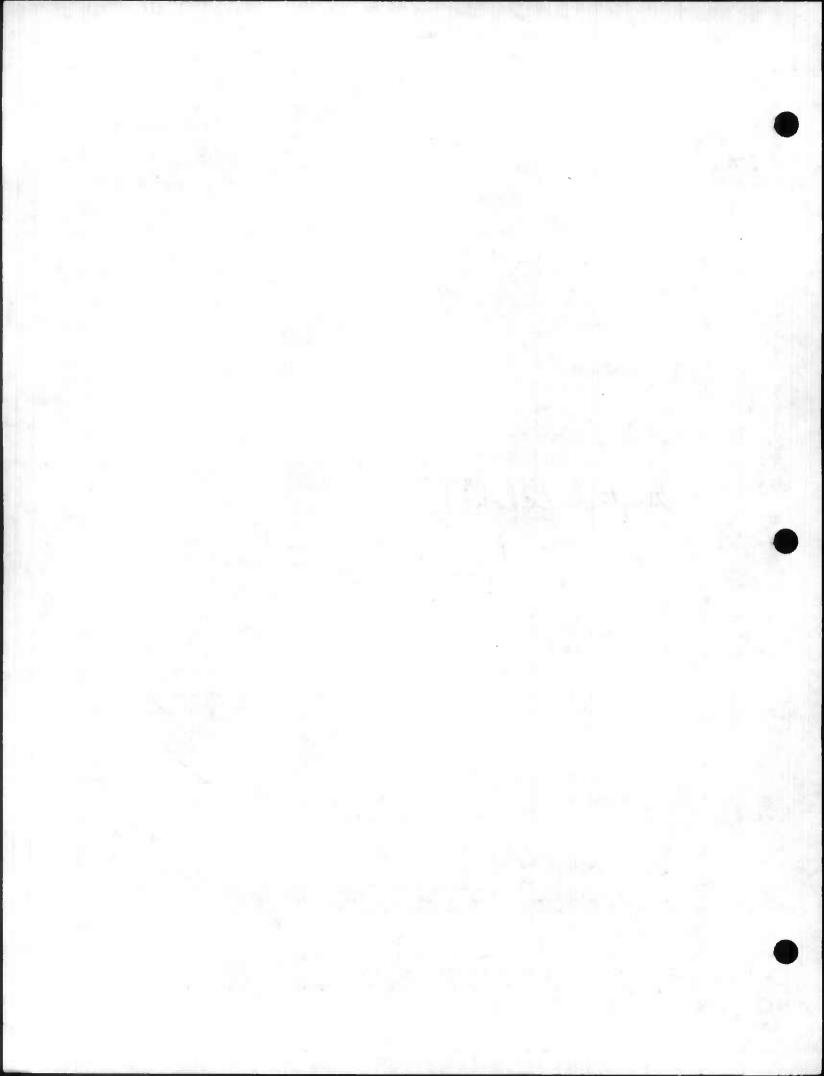


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State of Maryland / Department of Health and Mental Hygiene

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			17	ylan	~	,00	Di	0.	C.M.E	•		De	cember	28, 1999	
			30. Name and address of person	who completed ca	use of death										
			Joseph	rest	ane	-	III Pen	n St	reet,	Bal	timore	, Mar	yland 2	21201	
	Sta	te	31. Dete filled (Month) Day, Year	9 1999 32.	Registrar's		9. 1	200	1						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0338 **Physician** ROBINSON ARNOLO 1944 OFFISH BOL /Medical 4a Facility Name (If not institution, give street and number)
WASHINGTON BOUNTLY HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death Examiner TAKOWA BACK MONTGEN ERY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) August 19, 1926 If Under 1 Year 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1XIM 2□ F 212-13-0853 73 Director Jamaica, West Indies Usual Residence of Decedent the Meryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits **ehow** than "natural", or hama 23s or 28s-f show the Medical Examiner must be notified at 1 X Yes 2 No Maryland Prince George's Hyattsville Director 10a Street and Number 10f. Zip Code 10g. Cilizen of What Country? 20783 U.S.A. 7924 15th Avenue, #201 deeth v Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filled within 72 hours effer c Department of Heelth and Mental hygiene. Important: If item 27 ie marked other than "natural", or hen eny injury or other treumatic event, the Medical Example Black, White, etc. 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: P 3 Widowed 4 Divorced Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Private 12th Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Ada Roberts John Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1612 Pebble Beach Drive, Mitchellville, Maryland 20721 Zadoc V. Robinson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 20a. Method of Disposition 12/22 1999 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Beltsville, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 Nancy 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** ARTONOSCUTACTIC CALDIOVOSCULAL DISPOSE /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physician and a the buriel-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): for use as t signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Š 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed sertificete hes b lirector, page 2 e 1 Yes 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Nes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28h. Time of Certification: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29b. Sign ture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) D 15236 (OME) DECOMBON 17, 1991 CALL MARODIS, MO

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

DEC 2 1 1999

32. Registrar's Signature

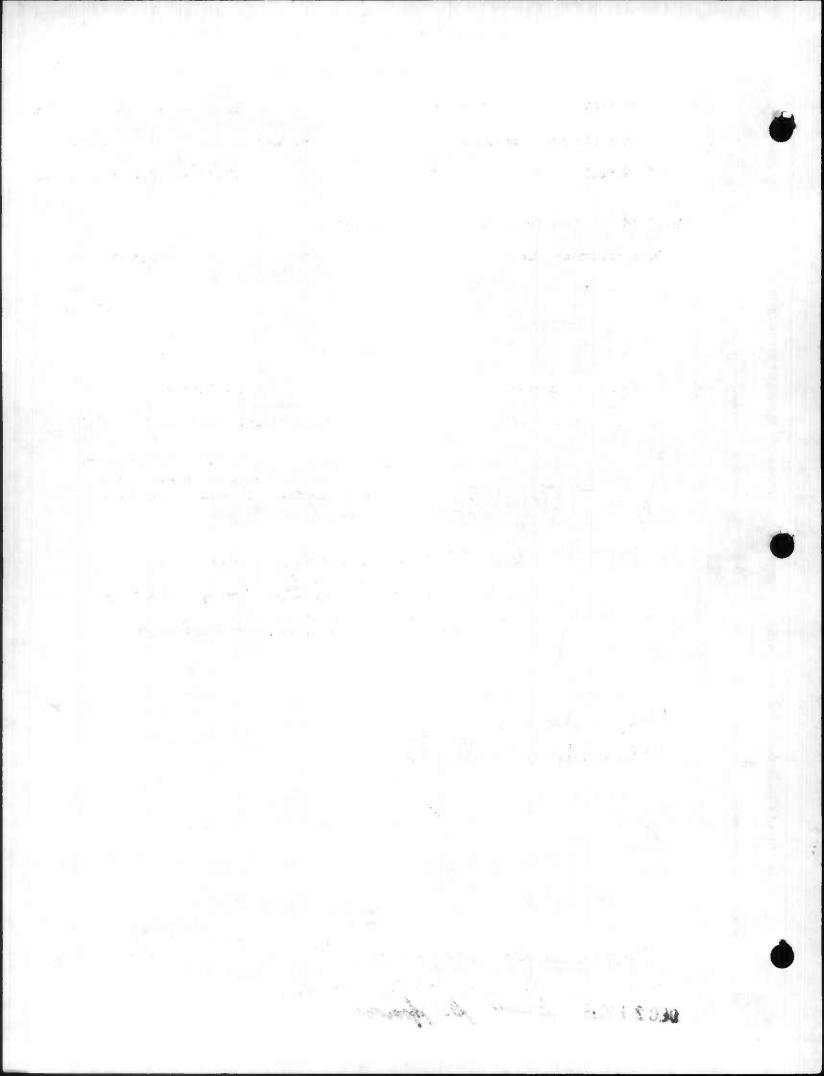
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State of Maryland / Department of Health and Mental Hygiene 99 4 87

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month **Physician** Herbert Rushing December 19 1999 4:48PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fort Washington Hospital Prince George's Ft. Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** 1₽M 2□F Months Days Yrs. 577-58-0887 58 **Director** March 4, 1941 Wash., Usual Rasidance of Decedant the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ?? Is marked other than "natural", or items 23a or 28a-f show treumstic event, the Medical Examiner must be not their 1 XYas 2 No Directo Maryland Charles Waldorf 10f. Zip Coda 10g. Citizan of What Country? 10e. Street and Number with 1 10209 Brairwood Place 20601 United States permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural, or items 23a any Injury or other treumatic event, the Medical Examinat manual others. Funeral Was Dacedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian. 12. Was Decedant Evar in U,S. Armad Forcas? Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Married African Baltimore, Maryland 21215-0020 1 ☐ Yas 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced American Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Elamantary/Secondary (0-12) Collaga (1-4or 5+) Supervisor Private 12th 18. Mothar's Nama (First, Middla, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Savanah Chambers Alexander Rushing 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Joan P. Rushing - Wife 10209 Brairwood Place., Waldorf, MD 20b. Piaca of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☑ Burlai 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 12/23/99 Clinton, MD 22. Nama and Addrass of Facility Stewart Funeral Home 21. Signatura of Funaral Sarvice Licensea 20019 4001 Benning Rd., N.E. Wash., D.C. 234. Park Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximata Intarval Batween Onset and Death **Physician** /Medical Immediata Causa (Finai MONOW Examiner Examiner attending physician and for usa as the burial-transit 30MC Sequantially list conditions, if any, laading to Immadiata causa. Enter Underlying Causa (Disaasa or Injury that initiated evants rasulting In daath) Last Dua to (or as a consequence Division of Vital Records, P.O. Box 68760, that the death certificate be Physician/Medical Qua fo (or as a consaquanca of): signed by tha a 23b. Did tobacco usa contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No ð 24b. Wara autopsy findings availabla prior fo compiation of causa of daath? 24a. Was an autopsy Completed paga 2 1 Yas 2 No 1 Yas 2 No certificate or Attending Physician: 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Chack only ona) Hospitai: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 2 1 Inpatiant 2 PER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Yaar) 28d. Dascribe how injury occurred 28c. Injury at Work? 28b. Time of Certification: After t 5 Panding invastigation s after death. 1 Yas 2 No 2 ☐ Accident 6 Could not be datarminad 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 3 ☐ Suicida filled in by 4 Homicida Hospital 24 hours 1 Certifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. edical 29a. Cartifian completely 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the To the 29b. Signatura and fitta of cartifian 29c. Licansa number 29d. Data signad (Month, Day, Year) 20 2405 MO KOU 30. Nama and addrass of person who compiated causa of death (Itam 23a) (Type, Print) 017 31. Data filed (Month, Day, Year)
DEC 2 1 1999 32. Ragistrar's signatura State Registrar

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Neme (First, Mid . Les 2. Dete of Deeth Physician 10 /Medical December 20,1999 4:35 AM 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Baltimore Bon Secours Hospital 5. Sociel Security Number 6. Sex If Under 1 Yeer If Under 24 Hrs. 7. Age (In vrs. lest birthday) Funeral 8. Date of Birth (Month, Dev. Yeer) Birthplace (State or Foreign Country) Deys Months Hours 1 M 350F Yrs. Director 42 Maryland January 30, 1957 230-88-5346 Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at Temple Hills Yes 2□ No Funeral Director Prince George's MD 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? with 20748 USA 2142 Anvil Lane deeth 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ♣☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Maritel Status 14. Raca - American Indien, Bleck, White, etc. filed within 72 hours after Never Merried 2☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 3 ☐ No Specify: Specify: Be Completed by 3 ☐ Widowed 4 ☐ Divorced Black 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Mental Health Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Mental Health Counselor 11 7 is marked other traumatic event, in 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) . Peges 1 and 2 should be fill iment of Health and Mental Heant: If Item 27 is marked oth jury or other traumatic even Rebecca Williams James Robinson 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 2142 Anvil Lane, Temple Hills, MD 20748 Sandra L. Winston/Sister 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Burial 2 ☐ Cremetion 3 ☐ Removel from State permit. Pege Depertment of Important: If any Injury or 12/23/99 Suitland, MD Washington National Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Enneral Service Licensee 22. Name and Address of Facility Cedar Hill Funeral Home, Inc. 4111 Pennsylvania Ave., Suitland, MD 20746 chilons that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, ause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Ceuse (Final diseese or condition resulting in deeth) **Examiner** consequenca of): Physician/Medical Examiner The law requires that the death certificete be executed buriel-trans Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es e consequenca of): P.O. Box 68760, physiclan the Due to (or es e consequenca of): 98 USB 0 Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? ate has been signed by page 2 should be detect 3 Probably ่⊒มก็known 1 | Yes 2 | No of Vital Records, þ Completed 24a. Wes en eutopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 Yes 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: filled in by the funeral director, Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes Certification: To 2 ER/Outpatient 3 DOA Inpatient this 27. Mennet of Deeth Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred After Division Neturel 5 Pending investigation Injury 1 ☐ Yes deeth. 2 Accident efter deeth 3 Suicide 6 Could not be determined 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital within 24 hours e To the Funerel C 29a. Certifier Medical Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and menner as stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) end manner stated.

State

31. Dete filed (M

and title of certifier

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Registrer's Signeture

29c. License number

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Registrar

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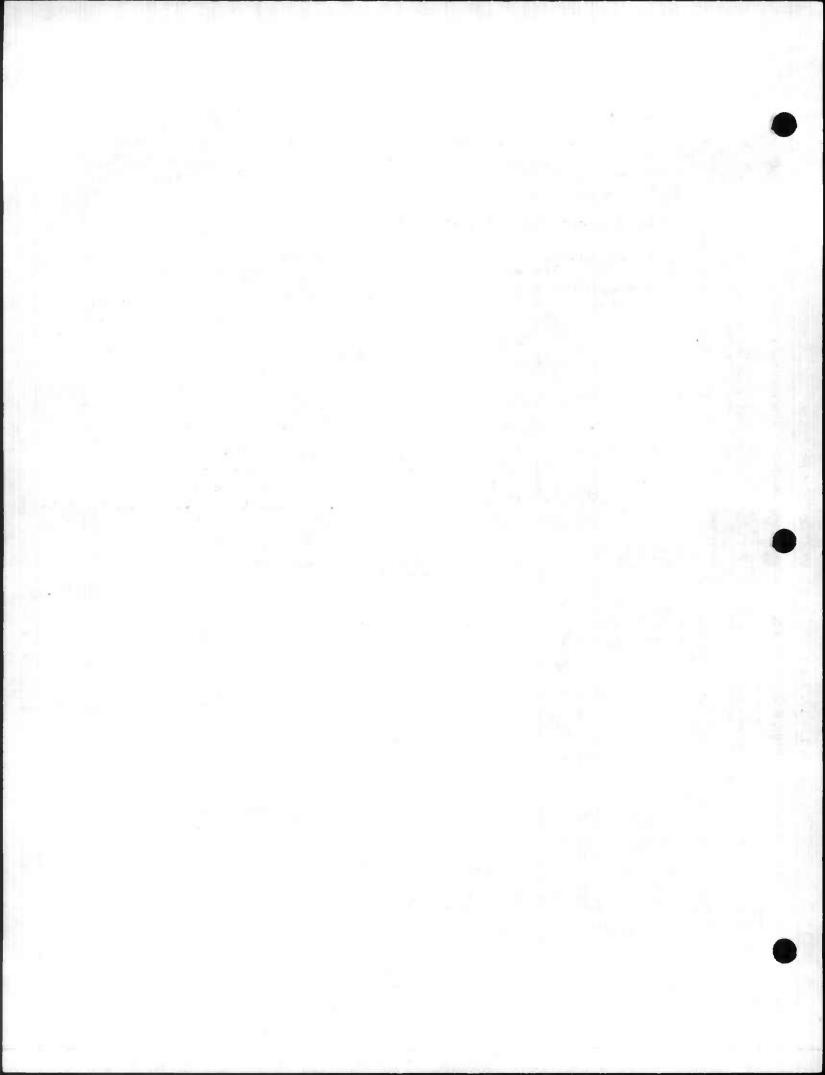
State of Maryland / Department of Health and Mental Hygiene

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	30. Name and address of person who	completed cause of dea	ith (Item 23a) (Type,	Print)		ckirlle						
	Dr A Mendhirat	à 2401 Resu	earch Bul) suito ?	340 RO	ckirlle	MD 20	850)			
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Swit, David



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 17, 1999 430 AM BAILEY MARJORIE DECEMBER /Medicat 4a. Facility Name (If not institution, giva straat and rumbar) 4b. City, Town, or Location of Death 4c. County of Death Examiner SANDY SPRING BROOKE GROVE REHABILITATION AND NURSING HOME MONTGONERY If Under 1 Yaar Months Days tf Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplaca (State or Foreign Country) 1 M 2 XF Hours Director 217-48-8396 84 April 29,1915 | Kentucky Usual Residence of Decedent the Maryland permit. Pages 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Heelth and Mental Hygiene. Important: If Itam 27 is merked other than "natural", or Itams 23a or 28a-4 show any Injury or other traumatic event, the Medical Expiritive must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d, inside City Limits 1 ☐ Yas 2 1 No Directo Maryland Montgomery Silver Spring 10f. Zip Code 10e. Street and Number 10g. Citizan of What Country? 2004 Lansdowne Way Funeral 20910 USA 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 ☐ Yes 2 ☑ No tf Yes, Give Year or Datas: 1 Never Married 2 Marriad ω Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No by Specify. 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner/Manager Health Food Store 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Charles Patterson Steele 2 Sara Ratcliffe 19a. tnformant's Name/Relationship (Type, Pript) (daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda P. C. Blackistone 2020 Lansdowne Way Silver Spring, Maryland 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cramation 3 X Removal from State Dec.27 4 ☐ Donation 5 ☐ Other (Specify) Georgetown Cemetery 1999 Georgetown, Kentucky 21. Signature of Funeral Service Licenses 22. Name end Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., Silver Spring, MD 23a. Part 1. Enter the disaase, or complications that deused the death. Do not anter the mode of dying, such as cerdiac or raspiratory arrast shock, or heart failure. List only one cause of each line. Approximate Intervel Between Onset and Daath **Physician** Immediate Cause (Finat disease or condition resulting In death) /Medical MINUTES DEIZURE **Examiner** Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting to deeth) Last Due to (or as a consequence of): Box 68760, physician Dua to (or as a consequence of) the etter P.O. Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? signed by the ALZHEIMER'S 1 ☐ Yes 2 No 3 Probably 4 Unknown DISEASE Division of Vital Records, þ Completed 24e. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of ceuse of death? this certificate 1□ Yes 22 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medicel examinar? Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 Other: 42-Nursing Home 5 Residence 6 Other (Specify) 1 Yes 24 No funeral 28a. Date of tnjury (Month, Day Year) Certification: 27. Manner of Death 28c. tnjury at Work? 28d. Describe how tnjury occurred After Netural 5 Pending Investigation 1 Yes 2 No deeth. 2 Accident efter deeth Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homtcide within 24 hours e To the Funeral D completely filled Medical 29e. Certifier (Check only one) 1 PCertifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) end mennar as stated.

2 Medical Examtner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) - STAFF PHYSICIAN D42046 DECEMBER 17, 1999 10

GRACE BROOKE HUFFMAN, MD 18100 SLADE SCHOOL FOAD SANDY SPRING, MARYLAND

20860

Registrar **DHMH 16 Rev 6/95**

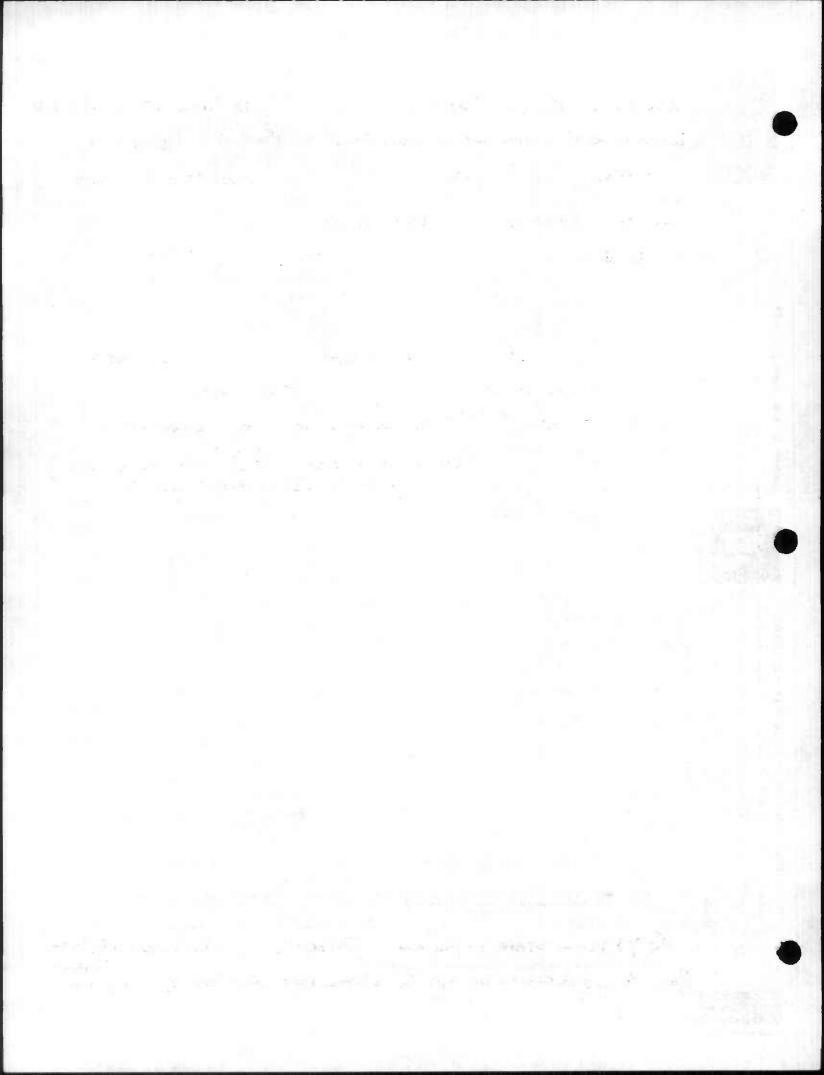
State

30 Name end address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Date filed (Month, Day, Year)

DEC 20



State Registrar

2

29b. Signeture and title of certifier

31. Date filed (Month Pay. Year)

Alpana

Raralponia

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Goswami, M.D.

1999

Suchez, Foxos 10

INTERNIST

32. Registrar's Signature

MD

29c. License number

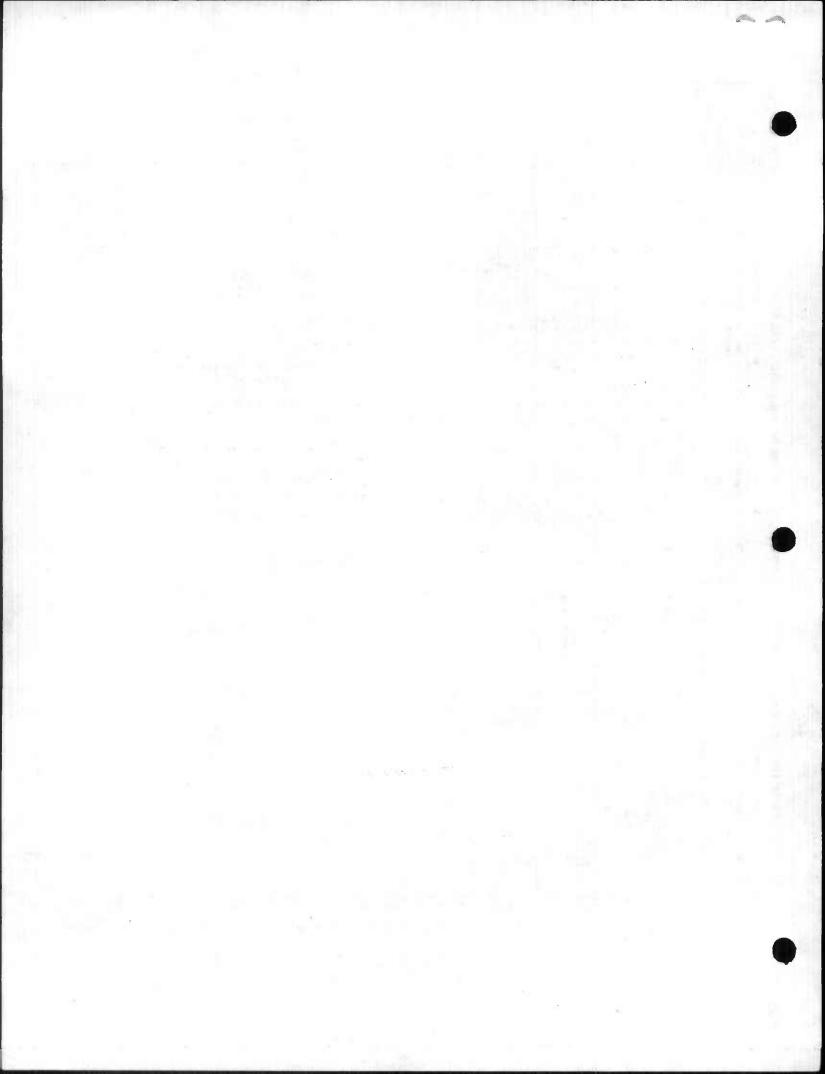
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10901 Connecticut Ave., Kensington, MD 20895

29d. Date aigned (Month, Day, Year)

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12/16/

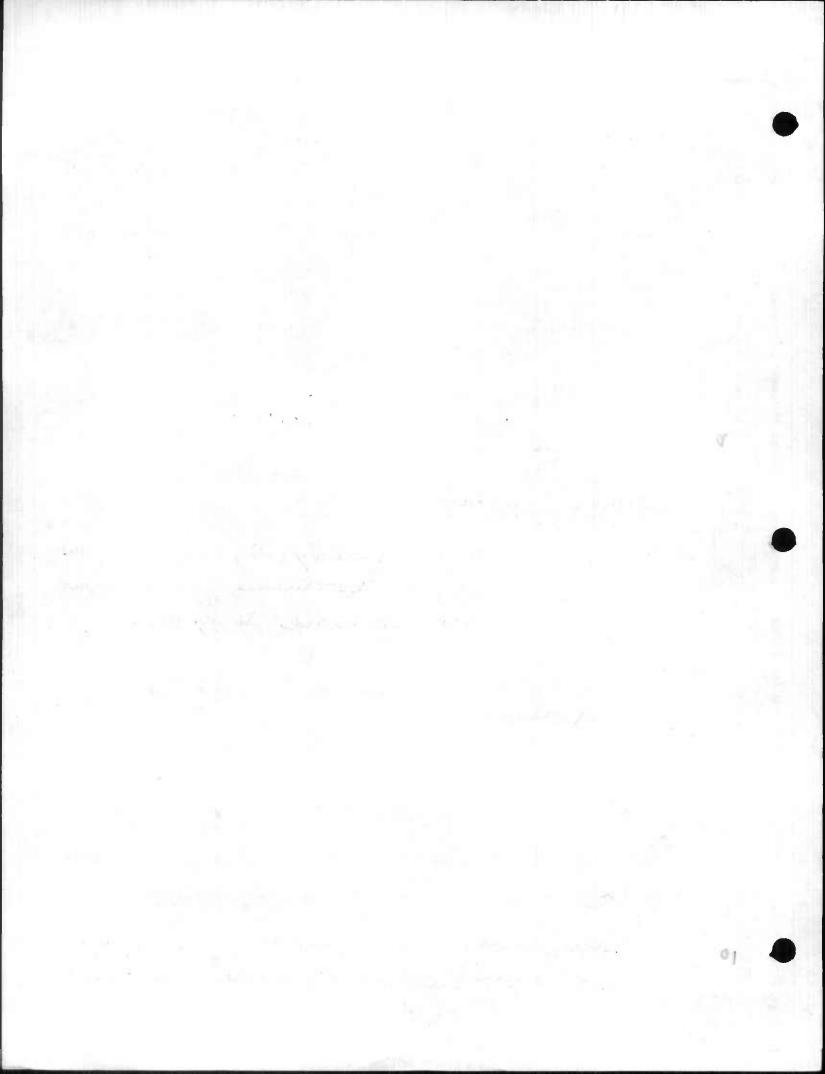


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State of Maryland / Department of Health and Mental Hygiene

	Decedent's Nama (First, Middla, I	asti	C	Certificate of	Death	2. Data of Dec	Reg. No.	3. Time of Deat			
Physician			01:1 0			Month Day Year					
/Medical	Dorothy Mac		ckley	-	4b Chi Taum and	December 20, 1999 8: Location of Death 4c. County of Death					
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pu *	Usual Rasidance of Decedent 10a. Stata 10b. County	10	c. City, Town o	or Location				10d. Inside City Lin			
a-f sho		omery		Chase			1 Yes 2 🗆				
or 28	10e. Sfreet and Number			10f. Zip Coda			10g. Citizen of W	/hat Country?			
th w	5100 Dorset Ave	nue, #413		208			USA				
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72 ho	15. Decedent's (Specify only highast)	Education	16a. D	ecedent's Usual Occu	pation	ina	16b. Kind of Bu	siness/Industry			
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parmit. Peges 1 at Department of Hear Important: If Item; any injury or other once.	21. Signatura of Funaral Sarvice Lic	Woold	ep		Street,	Alexand	ria, VA	Funeral Servi 22310-1025			
Physician	23a. Part1. Entar tha disaasa, or co shock, or heart failura. List on	mplications that causad that ty ona cause on each lina.	daath. Do no	t antar tha moda of dy	ing, such as cardiac	or raspiratory a	rrast,	Approximata Interval Between Onset and Death			
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Examiner	disease or condition resulting in death) Due to (or as e consequence of):										
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clan: The law requires that the deeth certificate be asscuted entificate hes been signed by the attending physician and octor, page 2 should be detached for use as the bunal-transit Be Completed by Physician/Medical Examir						24a. Wes	an autopsy ormed?	24b. Were autopsy findin available prior to completion of cause of death?			
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m: T or, pi	25. Wes casa referred to medical				26. Place of Dee			3.11			
sicia irect	axaminar?	Hospital:	2 ER/Outp	atient 3 DOA OI	ther: 4 Nursing H		dence 6 □Othe	er (Specify)			
Attending Physician: or death. ector: After this certification; by the funeral director, liftcation; To Be (27. Mannar of Death 1 Sel Netural 5 Pending 2 Accident invastiget	28a. Deta of Injury (Month, Day Ye	28b. Tin	na of 28c. Inju		6	how injury occurr				
FEEC E	3 Suicida 6 Could not	be Diese of John	At homa, fam pecify)	n, street, factory, office		28f. Location (City or To		er or Rural Routa Number,			
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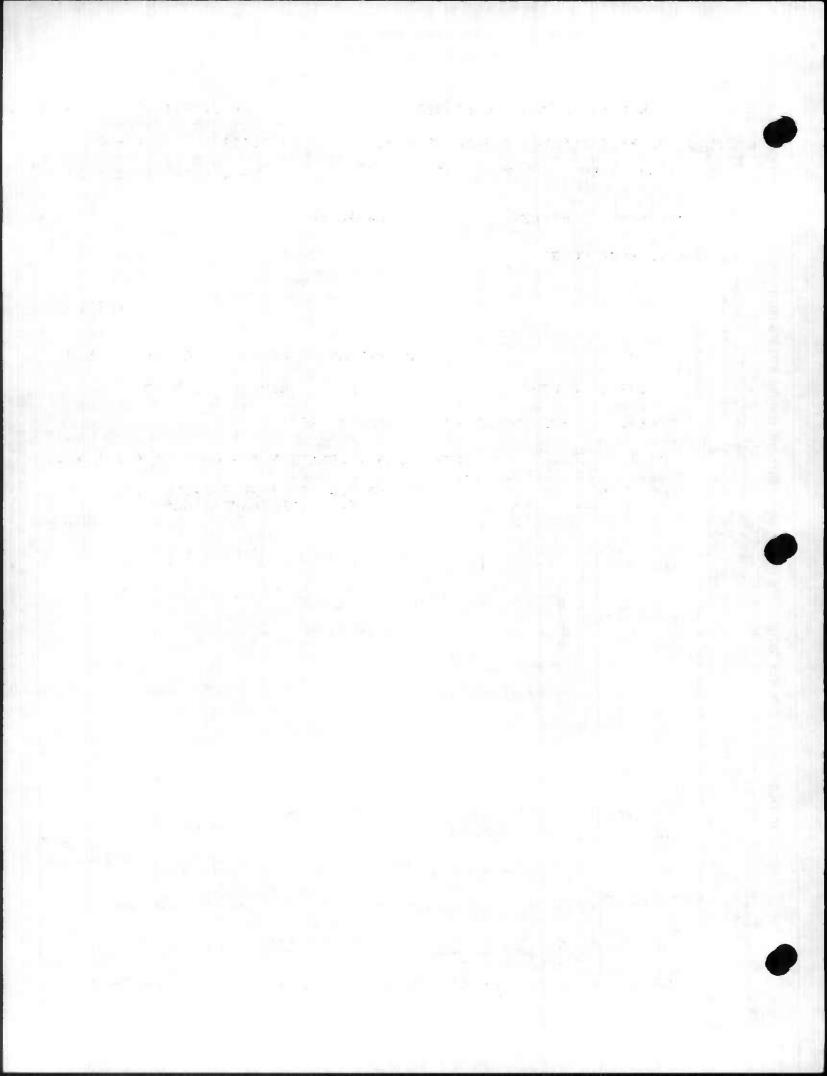


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Month **Physician** DEC.27,1999 9:00 P.M. HEDWIG N/M/N SCHNIERER /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner CHARLES GENESIS ELDERCARE NURSING HOME LA PLATA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2□x Days 215-06-7380 82 Yrs DEC. 4,1917 GERMANY **Director** Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2 No CHARLES LA PLATA MARYLAND Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medical Examiner must be 20646 U.S.A. 6050 ROSE COURT permit. Pages 1 and 2 should be filed within 72 hours effer death v Department of Haelth and Mentel Hygiena. Important: If Item 27 is marked other than "natural", or items 23a and Injury or other traumatic event, the Medical Examiner must poice. Funeral 14. Raca - American Indien, 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ 💢 to p 3 ☐ Widowed 4 ☑ Divorced WHITE Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 GROCERY STORE OWNER GROCERY SALES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be BARBARA LEIDNER JOHANN SCHWEHM 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) CHRISTEL HARDEE-DAUGHTER SAME AS #10 20b. Placa of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition N Burlal 2 □ Cremetion 3 □ Removal from State 4 □ Donetion 5 □ Other (Specify) SACRED HEART CEMETERY 12-30-99 LA PLATA, MD. 22. Name end Address of Fecility M00479 RAYMOND FUNERAL SERVICE, P.A. retroe LA PLATA, MARYLAND 20646 23a. Part1. Enter the disease, or complication that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final /Medical oral intake DOOT disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner His ton physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initioled events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 98 usa jo 23b. Did tobacco usa contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Unknown signed by t Division of Vital Records. by 24b. Were autopsy findings evallable prior to completion of cause of death? should I 24a. Was an autopsy performed? Completed cartificeta has b lirector, paga 2 s 2000 Physician: Be 25. Was case referred to medical 26. Plece of Deeth (Check only one) Other: 4 Hursing Home 5 Residence 6 Other (Specify) 1 Yes ONO 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Aftar this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural or Attending s after des. 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direc complately filled in by 4 Homicide Hospital 1st Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifie 30. Name and address of person who completed cause of death, (Herri 231) (Type, Print) DR. N. RO. WALDORF, MO. 20603 1657 6 URUSAMY FFICE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Mare DEC 2 9 1999

Registrar



Funeral Director

pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified anonce.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

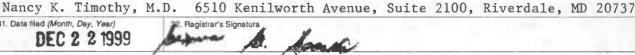
and I-transit The law requires that the death certificate be executed attending physiclan a for usa as the burial-Records, P.O. Box 68760. signed by the a is certificate has b I director, page 2 s Division of Vital Attending Physician: this funeral After death. i or Attendi aftar death Director: A To the Hospital or within 24 hours aft To the Funeral Di complately filled in

1. Decedant's Nama (First, Middla, Last) 2. Deta of Deeth 3. Tima of Death Day Month Vear Paul Wilson Winfield Stout 10:17 a.m. 16, 1999 December 4e Facility Nama (If not institution, give straet and number) 4b. City. Town, or Location of Deeth 4c. County of Death HyattsVIII

If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Yaar)
Feb. 2, 19 5817 31st Place Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) Months 120 M 2□ F Yrs 228-01-4161 81 1918 Washington, D.C. Usual Rasidance of Decedant 10a State 10c. City, Town or Location 10d. Insida City Limits 10b. County 187 Vas 2 No Maryland Prince George's Hyattsville Directo 10e Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? 5817 31st Place 20782 U.S.A. Funeral Was Decedant of Hispanic Orlgin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Rece - Amaricen Indian, 11 Marital Status 12. Was Dacedant Evar in U,S. Armed Forces? Black, White, atc. 1 ☐ Navar Marriad 2 ☑ Married ⊠Yas 2 □ No f Yes, Giva 1 Yes 21 No Specify. Specify: P 3 ☐ Widowed 4 ☐ Divorced White Yaer or Detes: WW II Completed 16a. Decedant's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) Collaga (1-4or 5+) Engineering Assistant WSSC 12 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Neme (First, Middla, Maidan Sumama) Be Willard Wilson Stout Florence Edna Jordan 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Numbar or Rural Routa Number, City or Town, Stete, Zip Code) Doris G. Stout - Wife 5817 31st Place, Hyattsville, MD 20782 20b. Place of Disposition (Name of camatary, cramatory or other place) 20a Method of Disposition Data 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/20/99 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 21. Signatura of Funaral Sarvice Licensaa 22. Name end Addrass of Facility Gasch's Funeral Home asc 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Daath Immediate Causa (Final disaase or condition resulting in death) Cardio Respiratory Arrest 5-10 min. Due to (or as a consequence of) Examiner 2-3 min. Exacerbation of Pulmonary Obstructive Disease Sequantially list conditions, if eny, laading to immediata ceusa. Entar Undarlying Cause (Disease or injury that initiated events rasulting in daath) Last Due to (or as a consequence of): 2-3 days Congestive Heart Failure Physician/Medical Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ▼ Yes 2 No 3 Probably 4 Unknown Arrythmia à 24b. Wara autopsy findings available prior to complation of cause of death? 24a. Wes en eutopsy performed? Completed Chronic Obstructive Lung Disease 1 ☐ Yas 2 ☒ No 1 ☐ Yas 2 ☐ No 25. Was cesa referred to medical axaminar? Be 26. Pleca of Daath (Chack only one) Othar: 4 ☐ Nursing Home 5 ☑ Rasidance 6 ☐ Othar (Specify) 10 1 ☐ Yes 2 ☑ No 1 Inpatiant 2 ER/Outpetient 3 DOA 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Tima of 28d. Dascribe how injury occurred 5 Panding invastigation 1 12 Natural 1 ☐ Yas 2 ☐ No 2 Accidant 6 Could not be datermined 3 Suicida 28a. Place of Injury - At homa, ferm, straet, factory, office building, atc. (Spacify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 4 | Homicide edical 15 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the bast of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifian (Check only one) 29c. Licansa number 29b. Signature and titla of certifiar 29d. Data signad (Month, Day, Year) Nancy Keelpana Simoly 20052848 December 21, 1999 MD 30. Name end eddrass of person who complated cause of daath (Item 23a) (Type, Print)

State Registrar 31. Data filad (Month, Day, Year) DEC 2 2 1999



DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Helen В. Sanalitro 5:30p 1999 December 20 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Doctor's Community Hospital Lanham Prince George's 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs 5. Sociel Security Number Birthplaca (State or Foreign Country) 7. Age (In yrs. last birthday) Hours Months 1□M 2\ F Yrs. 577-40-7114 March 1, 1918 Connecticut Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7500 Riverdale Road 20784 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Maritel Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give 1 ☐ Never Married 2 ☐ Merried 1 Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Associate Sears 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Thomas Januskas Barbara Yurgaitis 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Lynn E. Geida - Daughter 1722 Peartree Lane, Crofton, Maryland 21114 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 12/23/99 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cemetery 22. Neme and Address of Facility
Gasch's Funeral Home, P.A. 21, Signature of Funeral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ESOPHAGEAL CARCINOMA META STATIC 18 months Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1- Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury st Work? 1 Metural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

be executed Box 68760. P.O. Records, Division of Vital

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Physician

/Medical

Examiner

Funeral

Director

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"natural", or

permit. Pages 1 and 2 should be filled w Department of Health and Mantal Hygien Important: If New 27 is marked other tha any Injury or other traumeric other tha once.

Physician

/Medical

Examine

physician and the burial-transit

Examine

Physician/Medical

by

Completed

8

2

29a. Certifier (Check only one)

Helen Barbara Sanclitra

Directo

þ

Completed

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To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera edicai Certification: State

Registrar

aschabit

29c. License number 50686

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29d. Date signed (Month, Day, Year) 12/22/99

30. Nama and address of person who completed cause of deeth (Item 23e) (Type, Print)

EDMONSTON DRIVE ROCKVILLE. CLURDEEP S.CHMABRA MD SUITE 302 50 W

31. Date filed (Month, Day, Year)

29b. Signeture and title of certifier

DEC 2 2 1999



11.0 x x 1950 American

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

The Department of the August 14 days			Cen	tificate of	Death			J. No.	994	100/		
Decedent's Neme (First, Mida	lla, Last)					1	eta of Death Jonth	Dey	Yeer	Time of Death		
Estelle	Scott				th Ch. Tour		cember			1:35pm		
4a Facility Nama (If not institution		,			4b. City, Tow			4c. County				
Holy Cross H 5. Social Security Number		ge (In yrs. la	st birthday)	If Under 1 Year		r Spr		Montg		(State or Foreign		
578-62-1078	1□M 2⊠F	9	Vee	Months Days	Hours	Min.	ete of Birth Month, Day,	(ear)	Country)	(State or Foreign		
Usual Residence of Decedent							12,	1702	JC. IIII	ys ccysi		
10a. Stete 10b. County	1		Town or Loc							nside City Limits		
		Wa	isningt	on, D.C	•					Yas 2 No		
10e. Street and Number				10f. Zip Code 200	02		10	Og. Citizen of What Country? United States				
1536 D. Stree		t Francis II C	149 141			n2 (Canaih)	You as No		e - American Ir			
11, Marital Stetus 1 ☐ Never Merried 2 ☐ Mar	12. Wes Decedent Armed Forces rried 1 Yes 2	2		es Decedent of I Yes, specify Cub		Puerto Rica	n, etc.)		ck, White, etc.	idieri,		
3 ☑ Widowed 4 ☐ Divorced	If Yes (ive -	_	1	☐ Yes 2 No	Specify:			Specify	Black			
	nt's Education		16a. Decede	ent's Usuel Occup	pation		10	6b. Kind of B	usiness/Industr	у		
(Specify only higher Elementery/Secondary (0-12)	est grade completed) College (1-4or	5+)		ent's Usuel Occup ind of work done O NOT use retire				D 0	0			
3			La	undry Su	pervis	or		D.C.	Govern	ient		
17. Father's Neme (First, Middla,	, Last)				18. Mother's	s Name (Fir	st, Middle, Mi	riden Sumen	ne)			
Samuel Butler		e But										
19e. Informent's Neme/Relation				Address (Street								
Mary Giles/ D 20a. Method of Disposition	augnter	20b. Place of Disposition (Name of										
1 Burial 2 ☐ Cramation		Cei	metery, crem	etory or other ple			Date 20c. Location - City or Town, State 2/27/99Brentwood, Md.					
4 Donation 5 Other (5		Ft.		1n Cemet								
21. Signeture of Funeral Service	Consee		22.	Neme and Addra Alexande	r S. P	ope F	uneral	Homes				
23e. Part1. Enter the disaase, o shock, or heart feilure. List	more of1	285		5538 Mar						20747 proximete		
Immediate Ceuse (Finel disease or condition resulting in death) Bilobar Pneumonia Due to (or es a consequence of):												
Congestive Heart Failure Due to (or as a consequence of):												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury												
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	dons contributing to death t	but not result	ting in the und		ven in Pert I.		23b. Did tob	acco uae co	entribute to the	cause of death?		
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State of Maryland / Department of Health and Mental Hygiene 99 41888

						Ce	rtificate	of D	eath			Reg.	No.				
Physi /Med		Dacadant's Name (First, Fig. 1) CAT	iddle, La IERI	•	SEV	ERN					2. Dete of De Month	eth	Day , 199	Year 9	3. Time of I		
Exam		4e. Fecility Name (If not insti NATIONA				R	OCKV	ILL	cation of Deat	MONTGO		of Deeth	Deeth				
, Funera Directo		5. Social Security Number 218-42-677 Usual Residence of Deceder		ex □M 2 ∏ F	7. Age (In yrs. 95	Months Deys Hours Min. (Month, Day, Year) Country)							place (State or ntry) RYLAND	Foreign			
a-f ahow	ctor	10a. State 10b. Co	unty	ERY	10c. Cit	ty, Town or Lo	ocation OCKVI	LLE							10d. Inside City Limits 1 XYes 2 □ No		
oth with the Maryla 23a or 28a-f ahow	rai Director	10e. Street and Number 9701- V	EIRS	DRIVE			10f. Zip Co	ode 0850	0			10g.	Citizen of V		ntry?		
5-0020 12 hours after deeth with the Maryland netural', or items 23a or 28a-1 ahow Meal Examiner must be notified at	by Funeral	11. Merital Status 1 Never Married 2 \$\infty\text{\$\text{W}\text{idowad}} 4 \square \text{Divo}		Armed For 1 ☐ Yes If Yes, Giv	12. Wes Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Yeer or Detes: 13. Was Decede If Yes, specif 1□ Yes 2 □			Cuban,	enic Origin Mexican, I Specify:	n? (Spe Puerto I	ecify Yes or No Rican, etc.)	y Yes or No- ean, etc.) 14. Race - American in Bieck, White, etc. Specify: WHITE					
	Completed	15. Dec (Specify only h Elementery/Secondary (0- 1 2	1	ucation de completed) College (1	-4or 5+)	(Give life.	tent's Usuel C kind of work of DO NOT use i										
Maryland 212: d 2 should be filed within th and Mental Hygiene. 7 is marked other then traumatic event, the M	To Be C	17. Fether's Name (First, Mic JOHN W.						18			(First, Middle,		len Sumam	ne)			
e, Mary 1 end 2 sho Haaith and h em 27 is me ther traume		19a. Intormant's Name/Rele			CUTOR						ROCK				Code) 20850		
0 80= 8		20e. Method of Disposition 1 \(\frac{\text{XBuriel}}{2} \) Cremetion 3 \(\text{Removal trom State} \) 4 \(\text{Donetion} \) 5 \(\text{Other} \) (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) NEW CATHEDRAL CE								13	Date 1/23		LTIM	*	own, Stete MD •		
Baltim permit. Pa Department important: eny Injury once.		21. Signature of Funeral Strict Licensee 22. Name and Address of Fecility HYSONG CO., INC. FUNERAL HOME 1300— N STREET, NW, WASH., DC															
Certificate be executed ding physician end ding physician end is a set the burial-transit	Examiner	23a. Part. Enter the disease shock, or heart failure. Immediate Cause (Finel disease or condition resulting in daeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Carte Grity in	b.	Due to (o		Post uenca ot): uenca ot):								Approximate Interval Betwo	een eath	
H.O. BOX het the death cer do by the attendir datached for usa	by Physician/Medical	Part II. Other significant con Adeno can	ditions co	d intributing to dec				a given	In Part I.		23b. Did 1		co use cor	ntribute to	o the cause of bebly 4 U	death?	
HECOLO e lew requir has been s	Completed	Metuslise i	to le	res an	ed by	ne,	Sluis	F	lask	lalis	24a. Wes perfo	rmed'	topsy?	ev co of	ere eutopsy tin eilable prior to mplation ot cau deeth?	use	
or Attending Physiles death. Nirector: After this in by the funeral di	Certification: To Be C	3 Suicide 6 □ Co		28e. Date of (Month)		ER/Outpetien 28b. Time of injury ome, ferm, stre	28c.	Other: Injury et Work? 1 Yes	4 Nursi	ng Hom	(Check only one 5 Reside Rescribe to	dence	6 □Othe	ed			
To the Hospital within 24 hours a To the Funeral I completely filled	edical C	29a. Certifier (Check only one) Certifier (Medi	lying Phy cal Exam	sician: To the b	sis of examinat	wledge, death tion end/or Inv	occurred et the estigetion, in	ne time, my opini	date end p	olace, e	nd due to the o	cause date e	(s) and me and plece, a	nner es s	tated. the ceuse(s)		
To the tree to the component of the tree tree tree tree tree tree tree	Me	29b. Signature end titla of car 30. Name and address of pers	her	ompleted cause	ot deeth (Item	11. D	0	36	imber 6	8		29d. [Dete signed	Month,	Day, Year)	79	
9				TOPHER			9701-	VE:	IRS	DR.	, ROC	KV	ILLE	, MD.			

Registrar

DEC 2 0 1999

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Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 140Am Month **Physician** Slade hens 100 /Medical 4e Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silvers V055 mont 8. Dete of Birth (Month, Day,) Jan. 20, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Year) 1916 Edgecombe, N.C. 10 M 20 F Deys Min Months Hours 83 579-28-6935 Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 □ No Director Montgomery Silver Spring Maryland | 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 908 Hyde Rd. 20902 United States Herne 23a Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bieck, White, etc. 11. Meritei Stetus permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental hygiena. Important: if them 27 is marked other than "natural" any injury or other traumatic excessions. 1 ☐ Never Married 2 ☐ Married Specify: Black 1 Ves 2 No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Auditor Government 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Alonzo Slade Elizabeth Bess 19a. Informent's Neme/Reletionahip (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Audrey E. Stephens/Daughter 1816 Timber Lane Dr. Flint, Michigan 48507 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1 Burial 2 □ Cremation 3 □ Removel from Stete 12/28/99 Brentwood, Md. Ft. Lincoln Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerei Service Licensia 2A New and Address & Facility pe Funeral Homes 5538 Marlboro Pike/Forestville, Md. 20747 M1085 23a. Part P. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in deeth) Examiner Due to (or es e consequence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, it any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): P.O. Box 68760. Physician/Medical Due to (or es e consequenca of): 950 Por Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ Division of Vital Records, should t 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No for Attending Physician: after death. Director: After this certifica 25. Was case referred to medical exeminer?

1 Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 XER/Outpetient 3 DOA 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Puneral Funeral Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) and manner as atlated.

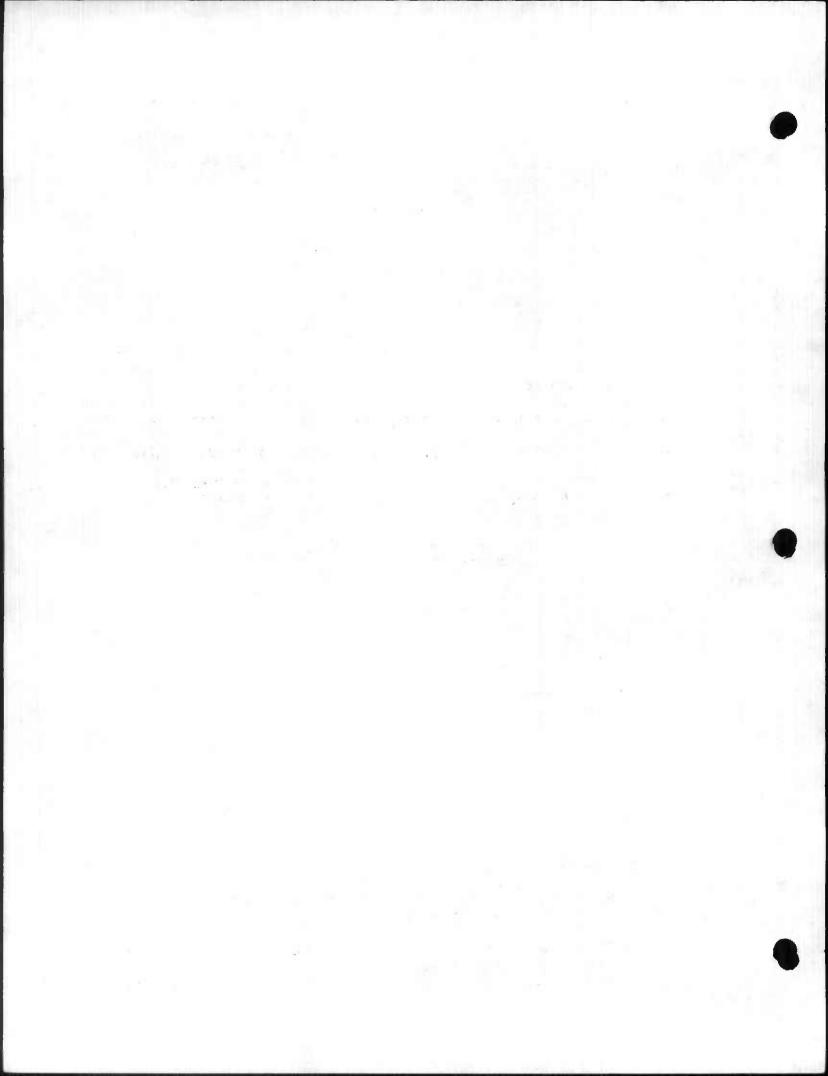
Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end pleca, end due to the cause(s) and manner stated. edicai 29a. Certities To the Hosp within 24 ho To the Functional (Check only one) 29b. Signature and title of certifier. 29c. License number + m OME 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) BRECKER, MO 31. Dete filed (Month, Dey, Year) 32 Registrer's Signeture State DEC 2 3 1999 Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 99 4 1890

					Cei	tificate of	Death		Re	g. No.	9 0-7	71020	
		1. Decedent's Nama (First, Middla, I	Last)						2. Deta of Death		V	3. Tima of Death	
Physici		JAMES I	DEC.	L6, 19	99	9:00 AM							
/Medic Examin		4a Facility Name (If not institution, g 5715 Dimes	ive street and number	RNER				wn, or Lo	ocation of Death 4c. County of Death 1e MONTGOMERY				
Funeral Director		5. Social Security Number 6. 213-20-8729	If Under 1 Yea Months Days	_		8. Date of Birth Month, Day, Sept. 15		9. Birthp	laca (State or Foreign				
		Usual Rasidence of Decedent											
r 28a-f show notified at	tor	MD 10b. County MD Montgo	omery	10c. City, To		cation					11	0d. Inside City Limits 1 ☐ Yes 🏂 No	
death with the Maryland res 23e or 28e-f show crinal be notified at	I Director	10e. Street and Number 5715 Dimes	Road			10f. Zip Code 2	0855		10	10g. Citizen of What Country? U.S.A.			
F 2 E	Funeral	11. Marital Status 1 Never Married Married	12. Was Deceder Armed Force 1 2 Yes 2 [s?	13. \	Was Decedent of I Yes, specify Cu	Hispanic Ori ban, Mexical	igin? (Spe n, Puerto l	cify Yas or No- Rican, atc.)		- Americ k, Whita,		
er, or	by	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Year or Data	44-46	5	I□Yes 210 No	Specify:			Specify:	ack		
72 hours after natural, or la edical Examina	Completed	15. Decedent's (Specify only highest g	Education grade completed)	16	(Giva	lent's Usual Occi kind of work don OO NOT use retir	e durina mos	st of worki	ng 1	6b. Kind of Bu	siness/Ind	lustry	
d within plane. r than	фшо	Elementary/Secondary (0-12)	College (1-4c			al Hus		Y		WR	AMC		
of 2 should be filed within 72 hours at this and Mental Hygieses. Then "caltures", or I'lls marked other than "caltures", or traumatic event, the Madical Exam	To Be C	17. Father's Nama (First, Middla, La. James H. Tu					18. Mothe	er's Name	(First, Middle, M	laiden Surnam	a)		
	-	19a. Informant's Name/Relationship Inez R. Turnes				_			al Routa Number, OCKVILL				
ages 1 a of of Hear or othe		20a. Mathod of Disposition 1 🖾 Burial 2 ☐ Cremation 3	Deta 20c. Location - City or Town, Stata /22/99 Olney, MD										
permit. Pages 1 as Department of Hear Important: If Iham: Iny Injury or other Stice.		21. Signature of Funeral Service Licenses 22. Name and Address of Facility P.A. SNOWDEN FUNERAL HOME; P.A.											
202#8		tonge K	·/no	wale	1	ROCKVI	LLE,	MD	20850				
		23a. Part 1. Entar the disease, or co shock, or haur hilura. List on	mplications that caus ly one cause on aach	ed the death. Do	o not ent	er the mode of dy	ying, such as	cardiac o	or respiratory arre	st,		Approximata Interval Between Onset and Death	
Physician /Medical		Immediate Cause (Final	mi	TIT	- 6	notes	36	~~-	,		1	years	
Examiner	-	disaasa or condition rasulting in death) Due to (or as a consequence of):											
and al-transit	Examiner												
sath certificate be executed attending physicien and for use as the burial-transit	Medical	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):											
death co			d						1				
d by th	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of de 1 Yes 2 No 3 Probably 4 Unke			
aw requires to been sign 2 should be	Completed by								24a. Was ar perform	autopsy ned?	ava	are autopsy findings allable prior to mpletion of cause death?	
	E O								1 ☐ Ya	s 2 No	10	Yas 2 No	
	Be	25. Was casa refarred to medical axaminer?					26. Place	e of Deeth	(Check only one	1)			
. € • ē	2	1 Yes 215€No	Hospital: 1 🗆 Inpe		Outpatien	R 3 DOA	Other: 4 No	ursing Ho	ma 5 Raside	nce 6 🗆 Othe	ar (Specif	y)	
Attanding Phirdeath.		27. Manner of Death 1 Netural 5 Pending 2 Accident investigati		njury Day Year) 28b	Tima of Injury	W	uryat ork? □Yes 2□		28d. Describe ho	w injury occurr	red		
	Certification:	3 Suicide 6 Could not determine	200. Place of	Injury - At homa, etc. (Specify)	farm, str	eet, factory, offic	9		28f, Location (Str City or Town		er or Rura	I Routa Number,	
To the Hospital or within 24 hours afte To the Funeral Dir completaly filled in	edical		Physician: To the besaminer: On the basis and manner	of examination a									
within 2 To the	¥.	29b. Signature and tile of certifier				29c. Lice	nse number		29	d. Data signed	d (Month,	Day, Year)	
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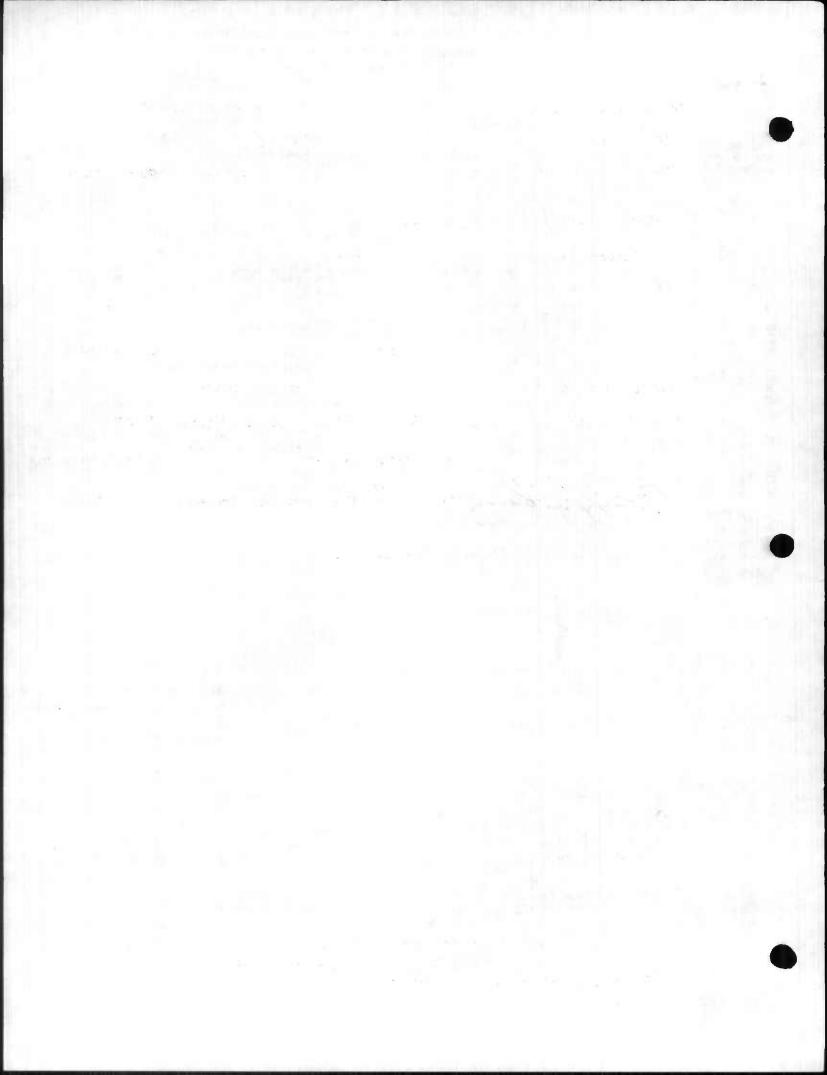
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State of Maryland / Department of Health and Mental Hygiene

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	3	30. Neme end eddress of p	erson who d	completed cause	of deeth (Ite	m 23a) (Typ	e, Print) Ya	hia M. Ta	gouri					
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State Registrar

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State of Maryland / Department of Health and Mental Hygiene Amend #'s 25.& 27. Per ME PGC 12-28-99 cr Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 5.15PM Lorraine Throne 12 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Prince George's Prince George's Hospital Center Cheverly If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 1 F 90 Yrs. 204-05-3131 Feb. 12, 1909 Pennsylvania Director Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the Medical Examinar must be notified as Maryland Prince George's Hvattsville 1 ☑ Yes 2 ☐ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3900 Hamilton Street 20781 U.S.A. deeth Funeral 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than "natural", or iten any injury or other treumatic event, the Medical Examinations. Black, White, etc. 1 Yes 2X No If Yes, Give Year or Detes: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager Hote1 12 18. Mother's Name (First, Middle, Malden Sumeme) 17. Father's Name (First, Middle, Last) Etta V. Boone James Robert Clemmons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 6411 Ivy Lane, Suite 414, Greenbelt, MD 20770 Stanley Pickett - Attorney Baltimore, 20b. Pieca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 € Burial 2 Cremetion 3 Removel from State 12/20/99 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 22. Name and Address of Fecility 21 Signature of Funeral Servica Licansee Gasch's Funeral Home COO 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting in death) PNEUMONIA 2 WEEKS ASPIRATION Examiner Examiner 13CH1A FRACTURE requires that the death certificate be executed physician and the burial-trans Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that Initiated events resulting in death) Last Due to (or as e consequence of): ALL Physician/Medical Due to (or as a consequence of): 80 Part II. Other significant conditions contributing to death but not resulting in the underlying cause give 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown MOILE STREAPH Division of Vital Records, by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy Completed OSTEOPOROSIS, SEVERE page 2 1 Yes 2 No 1 Tyes 2 No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific director 25. Wes case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) XXYes ENO P 28d. Describe how injury occurred
SUBJECT TRIPLED AT HOME funeral 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation Injury 11-14-901 1 ☐ Yes 2 No XX Accident 1100 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Accertifying Physician: To the best of my knowledge, death occurred et the time, dete end pieca, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end piaca, and due to the cause(s) and manner stated. 24 hours a edical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2510 KENILWORTH ONE RIVERDALE いまりり Wy 546 31. Date filed (Month, Day, Year) DEC 2 2 1999 3. Registrer's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Dete of Deeth 1. Decedant's Nama (First, Middla, Last) 3. Time of Death ^{Dey} 1999 DEC. **Physician** 21, 9:00 AM THORPE WILLIE B. · /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not Institution, giva street and numbar) 4c. County of Death Examiner CAPITOL HEIGHTS PRINCE GEORGE 515 DRUM AVENUE If Undar 1 Yaar | If Undar 24 Hrs. 8. Deta of Birth (Month, Day, Y JUNE 18, 5. Sociel Security Number 7. Aga (In yrs. last birthday) 9. Birthpleca (Stete or Foreign **Funeral** 1939 NORTH CAROLINA Months Deys 1 M 2 F 60 Yrs. Director 579-50-2468 Usual Residence of Decedant 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1√ Yas 2 No Director MARYLAND PRINCE GEORGE CAPITOL HEIGHTS 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 20743 U. S. A. 515 DRUM AVENUE Funeral death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Giva Yeer or Dates: 14. Race - Amarican Indien, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Meritel Stetus filed within 72 hours after 1 Navar Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry end Mentel Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) STORE CLERK 6TH GRADE PRTVATE permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 Ia marked oths any Injury or other traumatic event once. 17. Fether's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be **ESTHER** HARRIS THORPE LUTHER 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stata, Zip Coda) CAPITOL HGHTS., MD 20743 TYWANDA ROPER--DAUGHTER 515 DRUM AVE. 20a. Method of Disposition

1 Buriel 2 Cremetion 3 Removal from State 20b. Plece of Disposition (Name of cametery, crematory or other plece) 20c. Location - City or Town, Stete 12/27/99 LANDOVER, MD HARMONY MEMORIAL PARK 4 ☐ Donetion 5 ☐ Other (Specify) PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH ST., N. E. WASH.,

2.M. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. 524 - 8TH ST., N. E. WASH., D. C. Approximeta Interval Between Onset end Deeth **Physician** /Medical Immediete Cause (Finel diseasa or condition resulting in deeth) Years BREAST CANCER Examiner Dua to (or es a consaquenca of) Examiner attending physician and for use as the buriel-trensit Sequentielly list conditions, if any, leeding to Immadieta cause. Enter UnderlyIng Ceuse (Diseesa or Injury thet initialed avants Due to (or as a consequence of): certificete be execut Box 68760 Physician/Medical Dua to (or as a consequence of): resulting In deeth) Lest 23h. Did tohacco use contribute to the cause of death? Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert f. the 1 Yee 2 No 3 Probably 4 Unknown DIABETIS MELLITUS, INSULIN DEPENDENT Division of Vital Records, by 24b. Wara eutopsy findings available prior to completion of cause of daeth? 24a. Was an autopsy parformed? Completed certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes casa refarred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Aesidence 6 Other (Specify) 1 ☐ Yes 20 No 3 DOA 2 1 Inpatient 2 ER/Outpatient 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: after death.

Director: After to in by the funera 5 Pending Invastigation 1 Naturel 1 Tyes 2 □ No 2 Accidant 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ HomicIde Hospital of 24 hours Medical 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the besis of examinetion end/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) To the Within 2 29c. License number 29d. Dete signad (Month, Dey, Year) 29b. Signature and title of cartifier in A tuller **DECEMBER 21. 1999** D 40216 30. Name end eddress of parson who complated cause of deeth (Item 23a) (Typa, Print) 4333 OLD BRANCH AVE. MARLO HEIHGTS, MD M. D. DENNIS A. CULLEN, 32 Registrer's Signature 31. Dete filed (Month, Day, Year) DEC 2 2 1999

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Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Day Month Jecember 23 1999 06.30 MaryJane F. Timmons 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 8. Date of Birth (Month, Dey, Year) Nov. 29, 1921 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) Days Months Hours 1□ M 21 F 78 Yrs. 203-10-3464 PA Usual Residence of Decedent 10b County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Mercersburg Franklin 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 10048 Knob Road 17236 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ZNO If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 □XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Samuel W. Hawbaker Sarah Catherine Hawbaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vaughn R. Timmons Son 10789 Knob Road, Mercersburg, PA 17236 20c. Location - City or Town, State Welsh Run, 20b. Place of Disposition (Neme of 20a. Method of Disposition Date WeIsh Run Brethren Burial 2 Cremation 3 Removal from State 12/27/99 4 Donation 5 Other (Specify) Cemetery PA 21. Signature of Fehrent Service Licensee 22. Name and Address of Facility Lininger-Fries Funeral Home Inc., 47 N. Park Ave., Mercersburg, PA Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Centro varanta Accident 1 math disease or condition resulting in deeth) Due to (or es a consequence ot): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot) Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 € Unknown Sepris recurrent Premania 1 ☐ Yaa 2 ☐ No mannet univers and stage ripation rend 24b. Were autopsy tindings available prior to 24a. Was en autopsy melliter completion of cause of deeth? 1□ Yes 2□No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding investigation 1 Yes 2 No

the burial-transit and De exect Records, P.O. Box 68760. physician Physician/Medical 2 bengis be del P Completed page 2 s certificate Division of Vital I or Attending Physician: after death. Be Certification: To this funeral After Director: / To the Hosphan, within 24 hours after de To the Funeral Direct

Physician

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Department of Health ar Important: If Item 27 is any injury or other trait

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25. Was case reterred to medical 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide 6 Could not be 28t. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide 1 Caritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated.

29c. License number

018019

State Registrar

Medical

31. Date tiled (Month, Dey, Year)

29b. Signature and title of certifier

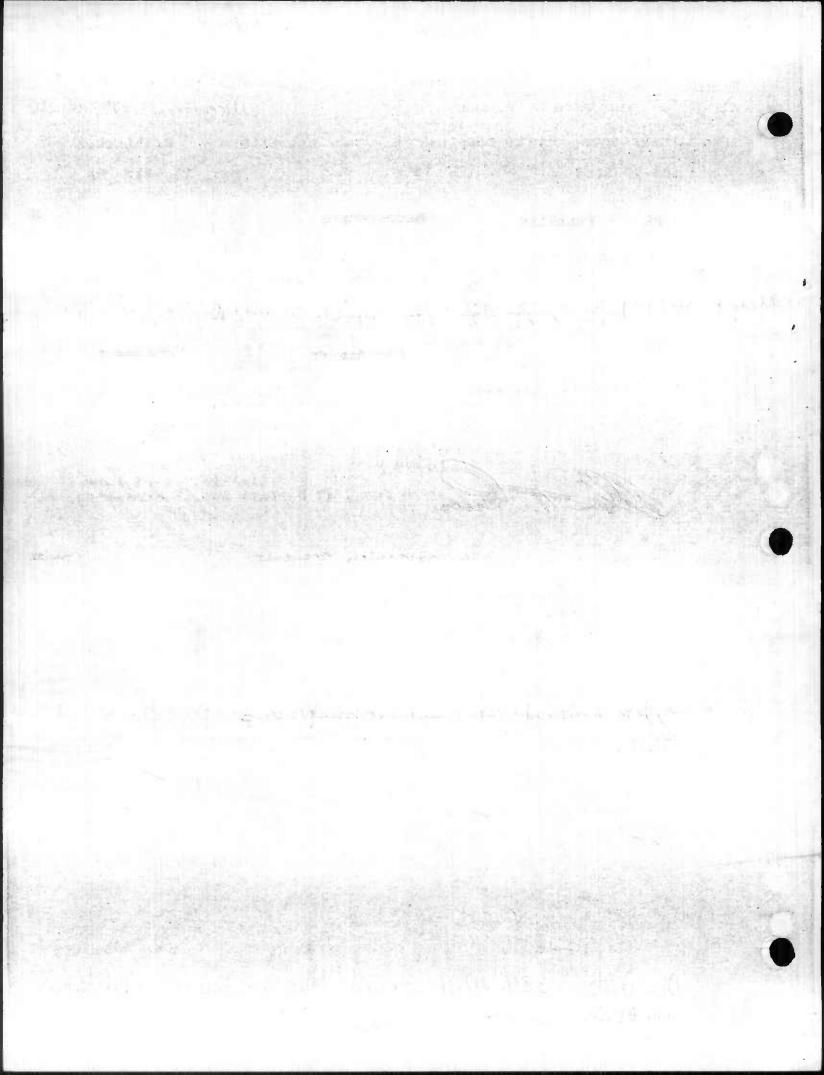
Name and address of person who completed cause of death (Item 23a) (Type, Print) 334 M.11 32. Registrar's Signature

DEC

29d. Date signed (Month, Dey, Year)

JAN 06 2000

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Peges nent of Int. If the Iny or or		4 □ Donation 5		Removal from State (y)	I EF			ns 12-2	7-99	Oaklan	d, MI			
Baltimore, N permit. Peges 1 and Department of Health Important: if item 27 any injury or other treasons.		21. Signature of Funer	al-Gervice Ligo	nsee Linb	00		4	Funeral 186, Day						
The second		23a. Pert1. Enter the a	diseese, or com	plications thet ceus	ed the death. I							pproximate		
687,60, ifficete be executed xg gphysician and as the buriel-transit	edical Examiner	disease or condition resulting In death) Sequentially list condition, leading to immediate. Enter Underlyticause (Disease or intert initiated events resulting in death) Las	ediete ng Iry	a. Metas	Due to (or as	s a consequ	ence of):	r			4	months		
			L	d										
BOX eath carti	lan													
. 73 0 0	Physician/M	Part II. Other eignifica	cant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause				
hat the ed by the detache	P P	Chroni	c Ohs	tructive	nuil e	Die	2250		1 X	Yee 2 No	3 Probal	bly 4 Unknow		
dS, F	d by	0111.0113		cr ac cr v c	Lung		Labe				0.4h 14/ava			
S S S S S S S S S S S S S S S S S S S	Completed	Corona	ary Ar	tery Dis	sease				24e. Was perfo	an autopsy ormed?	evalle	autopsy findings able prior to pletion of ceuse ath?		
= F age	Co								1 🗆	Yes 2X No	101	res 2□ No		
Vital Inside	Be	25. Was cese referred examiner?	to medical					26. Place of Death	(Check only	one)				
- Z 00	2	1 ☐ Yes 2√ No		Hospital: 1 Nnpa	tient 2□ER	/Outpatient	3□ DOA Oth	er: 4 D Nursing Ho	me 5 🗆 Resi	dence 6 Oth	er (Specify)			
	atlon:	27. Menner of Deeth 1 Netural 2 Accident	5 ☐ Pending investigatio		njury Day Year)	b. Time of Injury	28c. Injur Wor M 1	y et k? Yes 2 □ No	28d. Describe	how injury occur	red			
Direct of the bar of t	Certification:	3 ☐ Sulcide 6 4 ☐ Homicide	Could not be determined	289. Place of I	Injury - At home etc. (Specify)	, farm, stre	et, factory, office		28f. Location (Street end Number or Rural Route Number, City or Town, Stete)					
Fe the Acapital within 24 hours of to the Funeral Completely tilled	edical C	29a. Certifier 15 (Check only one)	Certifying Ph Medical Exam	nyalclan: To the bes miner: On the basis end menner:	of examination	dge, deeth end/or inve	occurred et the tin estigation, in my o	ne, date and plece, pinion, deeth occurr	end due to the ed et the time,	cause(s) and ma date and plece,	anner as state end due to th	ed. ne cause(s)		
To the	Me	29b. Signeture	of certifier	0	4111		29c. Licens	e number		29d. Date signe	d (Month, Da	ıy, Year)		
W/		1/10	enno	outh	mo		20.2	2464		D 0	7 70	00		
14		30. Neme and address	of person who	completed course of	death (Item 22	le) (Tunn f		3464		Dec. 2	1, 19	99		
10								Eglon,	TATE 7	6716				
Sta	10	31. Dete filed (Month, I						_	vv V Z	0110				
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DHMH 16 Rev 6/95

3-01-1921 Semplon, MD 85 With the Art of the legal in the A in COLOR DESCRIPTION OF PERSON CARAR DE MERMI DEL COLOR

The state of the s

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 10b per fh q779 1/19/00 yg Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** ERIC MARTIN WAGSHAL **DECEMBER** 21, 1999 1:10 A.M. /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner MONTGOMERY BETHESDA NATIONAL INSTITUTES OF HEALTH 8. Dete of Birth (Month, Dey, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplaca (Stete or Foreign **Funeral** 1⊠M 2□ F Months Deya Hours WASHINGTON, DC 54 10.02.1945 215.44.3538 Director Usuel Residence of Decedent the Maryland 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumstic evant, the Medical Examiner must be notified at Washington MONTCOMERY HAGERSTOWN 1 XYes 2 No MD Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21742 13536 THE HEIGHTS USA deeth Funeral 12. Wes Decedent Ever In U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Merital Stetus Bleck, White, etc. 2 should be filled within 72 hours efter on the Mental Hygiene. Is marked other than "natural", or its 1 Never Merried 2 Merrled 1 Tes 2 No Specify: Baltimore, Maryland 21215-0020 WHITE ρ Specify: 3 ☐ Widowed 4 ☐ Divorced 18e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) INTERNAL MEDICINE PHYSICIAN 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be LILLIAN RUBIN BENJAMIN WAGSHAL 2 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13536 THE HEIGHTS, HAGERSTOWN, MARYLAND 21742 19e. Informant's Neme/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health e
Important: If Item 27 is
any injury or other trau SHARON WAGSHAL/WIFE 20e. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 12.22.99 OLNEY, MARYLAND JUDEAN MEMORIAL GARDENS 4 ☐ Donetlon 5 ☐ Other (Specify) 22. Name and Address of Feellity EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signature of Funeral Service Licenses 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner physician end s the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseq Box 68760. certificete be Physician/Medical thet initieted events resulting in deeth) Lest 88 USB ò ed by the e Division of Vital Records. P.O. Pert II. Other significant conditions contributing to death but not reaulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 □ Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findinga aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed peen hes 1 ☐ Yes 2 No certificate 1 Yes Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Yea 2 ☑ No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2 1 Inpatient 3□ DOA 2 ER/Outpatient this uneral 27. Menner of Death 28d. Describe how Injury occurred 28a. Date of Injury (Month, Dey Year) Certification: 28b. Time of 28c. Injury at Work? After Attending 1 Naturel 2 Accident 5 Pending al or Attending a after death. investigetion 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homlcide 24 hours a Hospital 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as atated.
2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end piace, and due to the cause(a) end manner steted. 29e. Certifier Medical (Check only one) To the Vithin 2 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 99

State Registrar

10

9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 32. Registrer's Signeture souls

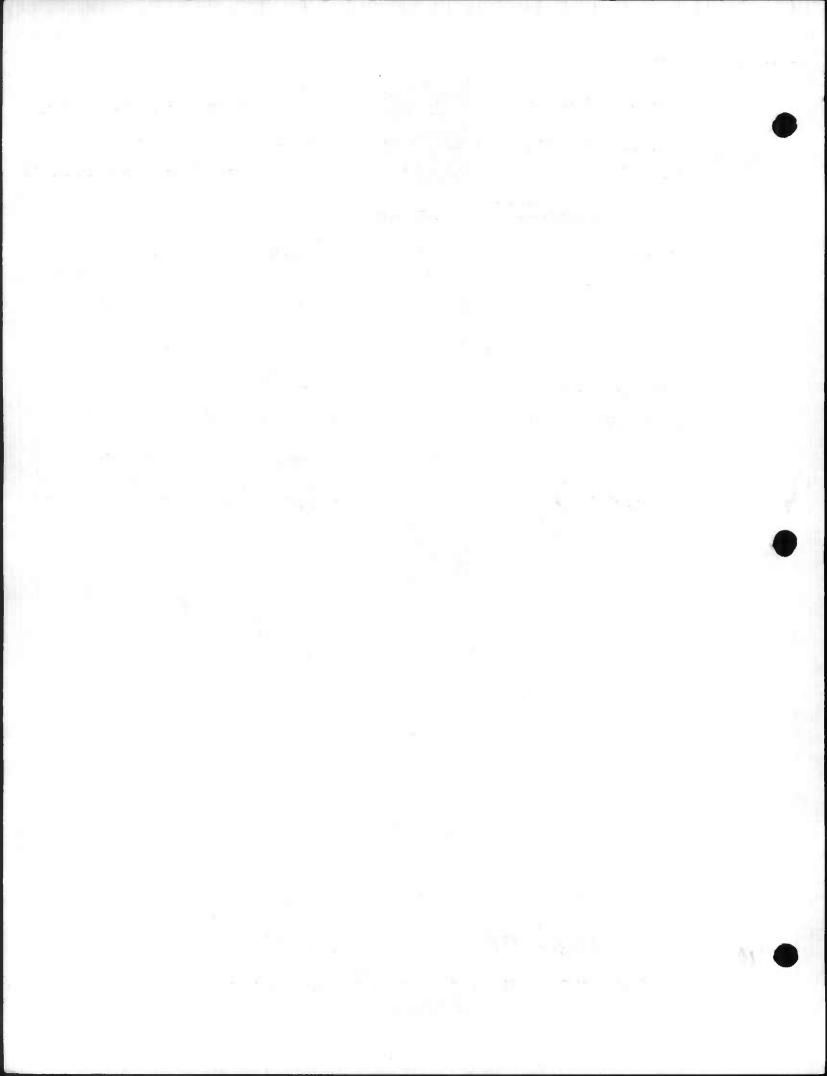
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

HENRY MASUR

DEC 23

31. Date filed (Month, Day, Year)

5/51



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** HOWARD THOMAS WALKER DECEMBER 18, 1999 12:45 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE MONTGOMERY 7. Aga (In yrs. last birthday) If Under 1 Year Months Days 8. Date of Birth (Month, Day, Jan 19, 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1₽M 2□ F 76 Virginia Director 231-05-1500 Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo 28a-f Maryland Montgomery Derwood 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? TRANT DR. Herra 23a 16401 Keats Terrace 20855 Funeral United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 M Yes 2 No Dec 42 Yes, Giva Year or Dates: filed within 72 hours after 1 ☐ Nevar Married 2 ☑ Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Aeronautical Hygiens. ther then Elementary/Secondary (0-12) College (1-4or 5+) Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 abouid be fill ment of Health and Mental H ant: If them 27 is marked off lury or other traumatic even Be 2 William . Herman Walker Alice Little Cox 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Betsy B. Walker, Wife 16401 Keats Terrace, Derwood, MD 20855 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a. Method of Dispersion
1 ☐ Burial 2 1 Gremation 3 ☐ Removal from Date 20c. Location - City or Town, Stete Dec 22, Department of important: If any injury or 5 Other (Specify) 4 Donatio Alexandria, Virginia Metropolitan Crematory 21. Signature of Furneral Service Licens 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877 -10.20 'n complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Final WK. disease or condition resulting in deeth) Examiner Examiner the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Box 68760. Physician/Medical Dua to (or as a consequence of) 88 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 K Unknown Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No certificate or Attanding Physician: funaral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 Natural 1 Yes 2 No 24 hours after death. 2 Accident 6 Could not be determined 3 Suicide 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Medical 29a. Certifier 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of car DECEMBER, 19, 1999 6+ 30. Nama and address of persol who completed cause of death (Item 23a) (Type, Print) 6

DHMH 16 Rev 6/95

State

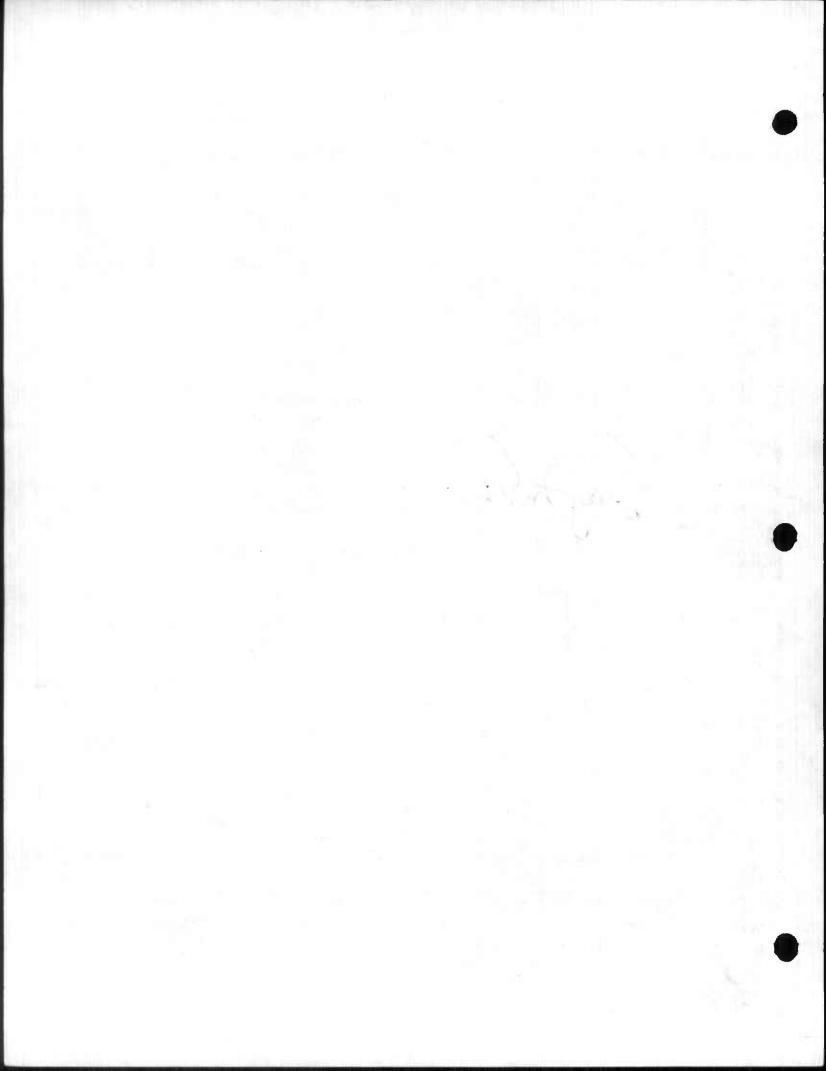
Registrar

SWAROOP.G.

DEC 2

32. Registrar's Signature

RAO: 50. W. EDMONSTON DR, ROCKVILLE, MD.



*, -	A	MEND#26 PER MD. G779 1	State of Maryland -6-2000 J.A.	/ Department of Certificate of			0.0	1,1000
		1. Decedent's Name (First, Middle, La	ist)	Oortmouto or		Reg.	NO.	3. Tima of Death
Physi		T C.	WILLIA	+M<	_	Month 19	Pay Year	2:30 PM
/Med Exam		4a Facility Name (If not institution, gh		,,,,,	4b. City, Town, or Locati	on of Death	4c. County of Dec	
EAGII		517 NORTH	+ MILTON +	AVENUE	BAIT	MORE	1	IA
Funera	ıt I	5. Social Security Number 6. 5	Sex 7. Age (In yrs. las	7 24 5 2 2 3 4 4	If Under 24 Hrs. 8	Date of Birth (Month, Day, Ye	o Ri	thplace (State or Foreign ountry)
Directo	r	217-34-4647	10 M 2□F 62	Yrs. Months Days	A A	PRIL 12	1937 G	EORGIA
pu .		Usual Residence of Decedent 10a. Stata 10b. County	10c, City.	Town or Location				10d. Inside City Limits
with the Maryland a or 28a-f show	10	MARIUNAIN	1/12	Ba	LTIMORE	1,7	7/	1ÆYas 2□No
the 1	Directo	10e, Street and Number	10 / / 7	10f. Zio Code	ZIMORE		Citizen of What C	ountry?
3a or	0	517 NOTH	MILTON AVE	NILE	21205	- /	USI	
death ime 23	Funeral	11. Marital Status	12. Wes Decedent Ever in U.S. Armed Forces?		Hispanic Origin? (Specify ban, Mexican, Puerto Rica	Yes or No-	14. Race - Am	erican Indien,
or he		1 Never Merried 2 Merried	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☑ No		iri, etc.)	Black, Whi	18, etc.
5-0020 72 hours after natural, or he	d by	3 Widowed 4 Divorced	Year or Detes:	12763 22110	у орвону.		Specify.	BLACK
21215-0020 d within 72 hours af giena. r than "natural", or the Medical East	Be Completed	15. Decedent's E (Specify only highest gro		16a. Decedent's Usuel Occu (Give kind of work done life. DO NOT use retin	e during most of working	16b	. Kind of Business	industry
2121 d within piene.	E	Elementary/Secondary (0-12) 5 + GRADE	College (1-4or 5+)	0	CHER		STORE	
De Hoo	Ü	17. Father's Name (First, Middle, Last)	Nare	18. Mother's Neme (Fi			
ld be wed a	ToB	UNKNOWN			ARIE		(1)1	LLIAMS
Maryland d 2 should be filed th and Mental Hyg 7 Ia merked othe treumatic avant,	-	19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Stree		oute Number, Cit		
e, M		BRENDA WILLIAM	MS (WIFE)	517 N. MIL	TON AVENU	E, BAL	TIHORE,	MD. 21205 Town, Stele
O se proper		20a. Method of Disposition	20b. Ple	ce of Disposition (Name of netery, crematory or other pla	ace)	Date 20c	Location - City o	Town, Stete
Baltimore emit. Pages 1. Appartment of He montant: If her ny injury or oth		1/3 Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	y) Woo	DLAWN CET	METERY 1/2-	23-99 3	ALTIMOR	E, HARYLAND
Ball mark my inj	ė.	21. Signature of Funerel Service Lice		22. Name end Addr	ress of Fecility	WIN JR	2. FUNE	RAL HOME
all.	2	Lutrel	N. Willia	-2140N	FULTON	AVE. &	BALTIMOR	E, MD. 21217
		23a. Pert1. Enter the diseese, or com- shock, or heart failure. List only	plications that caused the death.	Do not enter the mode of dy	ring, such es cardiac or re	spiretory errest,		Approximete Interval Between
Physician	_							Onset and Deeth
/Medica		Immediate Cause (Final disease or condition resulting in death)	. GASTRIC	ADENOCA	IRCINOM	A		3 MONTHS
ψ.		1050king in Goddin	Due to (or e	s a consequence of):				
De fied	Examiner		b					1
n and	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s e consequenca of):				
760	80	Cause (Disease or injury that initiated events	C. Due to for a	s e consequence of):				
	Pe	resulting in death) Last	Due to (01 e	s a consequence or).				1
W F A	Physician/Med		d					1
W death	aloi	Part II. Other significant conditions of	ontributing to death but not resulti	ng in the underlying cause g	iven in Pert f.	23b. Did tobec	cco use contribut	to the cause of death?
P.O.		DIABETES				1 Yes	2 No 3 1	Probably 4 2 Unknown
5 2 6 2	by						Lan	
6	etec					24a. Was an ex performed		Were autopsy findings available prior to completion of cause
The law	dE							of death?
The state	Be Completed					1 Yes	2 2 No	1 ☐ Yes 2 ☐ No
Division of Vital Records, or Attending Physician: The law equires, after death. Director: After this certificate has been again in by the funeral director, page 2 should be		25. Was case referred to medical examiner?	Hospitel:		26. Place of Death (C		A = 1 17	
O de de	170	1 ☐ Yes 2 No 27. Manner of Death	1 Li Inpatient 275cm	VOUIDATION 3LI DON	4 Ivuising nome	5 PA Residence Describe how in		ecity)
O But	tlor	1 Natural 5 Pending investigation	(Month, Day Year)	Injury Wo	ork? ☐ Yes 2 ☐ No			
VISI After After After Dy Illu	Hice	3 ☐ Suicide 6 ☐ Could not b	286. Pieca of injury - At nom	e, farm, street, fectory, office	28f.			Rural Route Number,
O Paris	Cert	4 Homicide	building, etc. (Specify)			City or Town, Si	rare)	
To the Hospital or within 24 hours att To the Funeral Dir completely filled in	Medical Certification:	29a, Certifier t⊠ Certifying Ph (Check only 2 Medical Exar	nysician: To the best of my knowle niner: On the basis of examinetion	edge, deeth occurred at the t	time, date end place, and	due to the cause	e(s) and manner a	is stated.
This the	Pel	ane)	end menner steted.					
2 1 2 8	2	29b. Signature and title of certifier	WILLIAM W. L	2 CATES 29c. Licen	nse number		Date signed (Mor	
		h.h.	House office	14	ES - 449	Dec	may	22, 1999
		30. Nama and address of person who WILLIAM W. LCCA	completed cause of death (Item 2	3a) (Type, Print)	OSPITAL TO	WER 110	BALTIMO	RE MARYLAND
		31. Date filed (Month, Day, Year)	32. Registrer's Signetur					7. 41. 74. 75
S Regis	tate trar	JAN 062	2000 Server	& space	K			
		WI III	-					

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Registrar

DHMH 16 Ray 6/95

9. J. Gra-

1985年 1980年

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

Months

10f. Zip Code

Microbiologist

20b. Plece of Disposition (Name of cametery, cremetory or other plece)

19803

1 Yes 2 No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

7. Age (In yrs. last birthday)

10c City Town or Location

Wilmington

88

12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:

College (1-4or 5+)

5+

State of Maryland / Department of Health and I			11000
Certificate of Death	Reg. No.	ココ	41900
. Decedent's Name (First, Middle, Last)	2. Date of Death	-	3. Tima of Death
Nancy Mitchell Wende	December 21,	1999	5:45 p.m.

Lanham

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min.

4b. City, Town, or Location of Death

8. Date of Birth (Month, Day, Year)

July 6,

18. Mother's Name (First, Middle, Maiden Sumeme)

Date

Wilma Potts

8700 Nightingale Drive, Lanham, MD 20706

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code)

4c. County of Deeth

10g. Citizen of What Country?

U.S.A.

Specify:

Dupont

16b. Kind of Business/Industry

20c. Location - City or Town, State

Prince George's

14. Race - American Indian,

White

Black, White, etc.

Missouri

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 Ves 2 No

Physician /Medical Examiner

5. Social Security Number

222-09-3896

10a State

Delaware

11 Marital Status

10e. Street and Numbe

Director

à

Completed

Usual Residence of Deceden

1912 Marsh Road

1 ☐ Never Married 2 ☐ Merried

3 ☑ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

Robert E. Mitchell

19a. Informent's Name/Relationship (Type, Print)

Charles D. Wende - Son

1 ☐ Buriat 2 ☑ Cremetion 3 ☐ Removel from State

4a Facility Name (If not institution, give street and number)

10b. Counts

New Castle

15. Decedent's Education (Specify only highest grade completed)

Magnolia Center Genesis ElderCare

6 Sex

1 M 2 F

Funeral Director

the Meryland 7 is marked other than "natural", or itema 23a or 28a-f show treumatic event, the Master Exerciper must be notified at deeth

permit. Peges 1 and 2 should be filed within 72 hours effer a Department of Health and Mentel Hygiene. Introduced in mortant: if fem 27 is marked other than "natural", or her any injury or other treumatic event, the Men

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

> physicien and the buriel-transit 20 080 algned b should should 804 page 2 this After deeth.

The law requires that the desth certificate be executed

Box 68760.

Records, P.O.

Division of Vital Attending Physicien:

To the Hospital or Attendir within 24 hours after death. To the Funerel Director: At completely filled in by the fu 0

State

Registrar

21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Gasch's Funeral Home 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart teilure. List only one cause on each line. Immediete Cause (Finel disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert t. Olympalara Rheumatila ģ - brell ation Completed 25. Was case referred to medical examiner? 8 26. Place of Deeth (Check only one) Hospital: 1□ Yes 212 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 (Natural 5 Pending investigation 1 TYes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, tarm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifie recent ou

12/22/99 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 4739 Baltimore Avenue, Hyattsville, MD 20781 Approximete Interval Between Onset and Death refurtatio whom comer (month 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Other: 4☑ Nursing Home 5☐ Residence 6 ☐ Other (Specify)

> 29d. Date signed (Month, Dey, Year) December 22, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David S. Granite, M.D., 115 Centerway, Greenbelt, MD 20770

DEC 2 2 1999

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Fort Washington

10c. City, Town or Location

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 2. Data of Deeth 3. Time of Death 1. Decedent's Name (First, Middla, Last) Month 1999 17 Ruth T. Weaver December 7:40PM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Prince George's Southern Maryland Hospital Clinton If Under 1 Yeer | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign 1□ M 2₽ F Yrs. 74 Wash., May 8, D.C.

10d. Inside City Limits

3 Probably 4 Unknown

24b. Wara autopsy findings evailable prior to

2 No

complation of cause of death?

1 Yas 2 No

Yes 2 No

Funeral Director

Physician

/Medical

Examiner

5. Social Security Number

10a. Stata Maryland

11 Maritel Status

579-30-8463

Usual Rasidanca of Decedent

10b. County

Prince George's

Directo Funeral by Completed

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiene. Ill important: If Itam 27 is marked other than "natural", or items 23s or 23s-f show any injury or other traumatic event, the Wedical Experient must be published.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

attanding physician and for usa as the bunal-transit The law requires that the death cartificate be axecuted Division of Vital Records, P.O. Box 68760, tha signed by t been signature has cartificata or Attending Physician: Aftar this funeral daath. I Director: A aftar

24 hours a within 2.

Certification:

Medicai

Elamentary/Secondary (0-12) 11th 20a. Mathod of Disposition Immediata Causa (Final disease or condition rasulting in death) Physician/Medical Examiner Sequantially list conditions, if eny, laeding to Immadiate cause. Enter Underlying Causa (Disaase or Injury that Initiated evants rasulting in daath) Lest by Completed Be 10 1 Yes

10e. Street and Number 10f. Zip Code 10g. Citizan of Whet Country? 20744 6812 Southfield Road United States 12. Was Dacadant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ∑ No If Yas, Give Yaar or Datas: 14. Rece - Amarlcan Indian, Black, White, etc. 13. Was Decedant of Hispenic Orlgin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, etc.) 1 ☐ Nevar Married 2 ☐ Married 1 Yas 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use ratired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Radio Broadcasting Private 17. Fathar's Neme (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Lewis Maiden, Sr. Naomi Kelly 19a. Informant'a Nama/Ralationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) William Maiden - Brother 6812 Southfield Rd., Ft., Wash., MD 20b. Placa of Disposition (Nama of cemetery, cramatory or other plece) 20c. Location - City or Town, Steta 1 ☐ Burlel 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 12/27/99 Lincoln Memorial Cem. Suitland, MD 21. Si natura of Funeral Sarvice Licanse 22. Nama and Addrass of Facility Stewart Funeral Home 20019 4001 Benning Rd., N.E. Wash., D.C. 23a. Parn. Enter the disease, or complications that caused the deeth. shirtly, or heart failure. List only one cause on each line. Approximeta Intervsi Between Onset and Death Do not antar the mode of dying, such as cardiac or respiretory arrast,

23b. Did tobacco use contribute to the cause of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 20 No 1 Yes 24e. Wes an autopsy performed?

25. Was casa referred to madical 26. Placa of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 20 No 2 ER/Outpatiant 3 DOA Data of Injury (Month, Day Year) 27. Manuar of Death 28d. Dascribe how injury occurred 28c. Injury at Work? 1 Neturel 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28a. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, deeth occurrad at the time, deta and place, end due to the ceuse(s) end menner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end piece, and due to the cause(s) and manner stated. (Check only one) 29d. Data signad (Month, Day, Year) 29b. Signatora end titla of certifier 29c. Licansa number

30. Name and addrass of person who complated causa of death (Itam 23a) (Typa, Print)

-245 10 Old MIP

XMI ERWA 31. Data filad (Month, Day, Year)

DEC 2 2 1999

2. Registrar's Signeture

Registrar

OEC 2 2 1999

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

	Otate of Inta		epartment of Certificate of			Reg. No.	9 41902		
Decedent's Name (First, Middle, L	ast)				2. Dete of De Month	ath Dey	3. Time of Deat		
FLOYD 1	FERNANDO	WI	GGINS		DECEMBE		1999 6:00 AM		
Facility Name (If not institution, gi	ive street and number)			4b. City, Town, o	or Location of Death				
916 Balboa Ave.				Capito	1 Heights	Prin	ce George's		
Social Security Number 6.	Sex 7. Age	(In yrs. last birtho	Months Day		rs. 8. Dete of Bird in. (Month, De	th Year)1956	Birthplace (State or Fore Country)		
579-76-1312	207	43 Yn			January	12,	Washington, D		
sual Residence of Decedent Oa. State 10b. County		10c. City, Town o	r Location				10d. Inside City Lim		
Maryland Prince	George's	Capito	1 Heights				1⊠ Yes 2□		
De. Street and Number		-	10f. Zip Code			10g. Citizen of V	What Country?		
916 Balboa Ave			207	13		Unite	d States		
1. Marital Status	12. Was Decedent E	ver in U,S.	13. Wes Decedent of If Yes, specify Cu		(Specify Yes or No		e - American Indien,		
1 Never Married 2 Married	Armed Forces? 1 ☑ Yes 2 ☑ N If Yes, Give	0	1 ☐ Yes 2 ☒ No		erto Hican, etc.)		ck, White, etc. Black		
3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		ILITES ZEIN	Specify:		Specify	; DIACK		
15. Decedent's E (Specify only highest gr		10	ecedent's Usual Occ	during most of w	vorking	16b. Kind of Bu	usiness/Industry		
Elementary/Secondary (0-12)	College (1-4or 5	·) //i	le. DO NOT use retir	ed)		Dest	2		
7. Father's Name (First, Middle, Las	4	11	umber	18 Mothade N	lame (First, Middle,	Priv			
Floyd Wiggins,					stine Key				
9a. Informant's Name/Relationship		19h M	lailing Address (Stre	1			State, Zip Code)		
Christine Wiggi			Balboa A				20743		
Da. Method of Disposition		20b. Place of D	isposition (Name of		Dete		City or Town, Stete		
1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		cemetery,	ciematory or other p. id Veteran		12/22/00	9Cheltenham, Md.			
Signature of Funeral Service Lice		maryian					irom, iro		
Varta a. A	ener MID	8-		_	e Funeral ke/Forest		Md. 20747		
immediate Cause (Final issease or condition asulting in death) sequentially list conditions, any, leading to immediate ause. Enter Underlying lause (Disease or injury nat initiated events asulting in death) Last	CARDIO-	-PULMONA] Due to (or as a cor -MYOPATH: Due to (or as a cor true to (or as a cor	Y nsequence of):						
nt II. Other significant conditions	contributing to death bu	t not resulting in th	ne underlying cause (iven in Pert t.	23b. Dld	tobacco usa co	ntribute to the cause of de		
	DIABET	ES			10	Yas 2 No	3 Probably 4 Unki		
						an autopsy ormed?	24b. Were eutopsy lindin available prior to completion of cause of deeth?		
					10	Yes 2 No	1 Yes 2 No		
5. Was case referred to medical				26. Place of D	Deeth (Check only o				
examiner? 1 Yes 2 No	Hospital:	nt 2 ER/Outp	atient 3 DOA	ther:	Home 5 Resi		ner (Specify)		
7. Nanner of Death 11 Natural 5 Pending 2 Accident investigation	28a. Date of frijun (Month, Day	28b. Tirr	e of 28c. In		A	how injury occur			
3 Suicide 6 Could not determined			, street, lectory, offic	, lectory, office 28I. Location			tion (Street and Number or Rurel Route Number, or Town, Stete)		
4 nomicide		my knowledge, d	eath occurred et the r investigation, in my	time, date and pla opinion, deeth oc	ace, end due to the ocurred et the time,	cause(s) and me date and plece,	enner as stated.		
9a. Certifier 1 Certifying P	hysician: To the best of miner: On the basis of and manner stat								
9a. Certifier 1 Certifying P	miner: On the basis of			399	1		ed (Month, Day, Year)		
9a. Certifier 1 Tacertifying P (Check only one) 1 Medical Exa	miner: On the basis of and manner stal	ed.	D10		1		od (Month, Day, Year)		
9a. Certifier (Check only one) 1 Certifying P (Check only one) 1 Medical Example of certifier	miner: On the basis of and manner stal	ed. ath (Item 23a) (Ty	D10	399		DECEMBER	ed (Month, Day, Year)		

Stat Registrar

Physic Medi

Funeral

permit. Pages 1 and 2 should be filed within 72 hours shar desth with the Maryland Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural", or Items 25a or 25a-f show any injury or other traumatic event, the Medical Examinar must be notified at one

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

986 x 936

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month **Physician** Day 8.38m leams CP /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner ood Side Montgo mer SILVER SPRING If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number Birthpiece (Stete or Foreign Country) 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day **Funeral** Deys 1 □ M 2 X F Yrs Director 253-32-9856 93 5/2/06 SMITHVILLE, GA. Usual Residence of Decedent the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show adical Examiner must be notified at N/A Director WASHINGTON 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20019 824 DIVISION AVENUE NE USA Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 20 No if Yes, Give Year or Dates: Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bieck, White, etc. Peges 1 end 2 should be filed within 72 hours effer or ont of Heelth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or ites 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16e. Dacedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Coliage (1-4or 5+) 12 YEARS NONE TAX PREPARER SELF-EMPLOYED 7 is marked other traumatic event, Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be OSCAR MITCHELL 2 LEOLA WELLS 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) CLAUDETTE MITCHELL (NIECE) 3123 63RD PLACE, CHEVERLY, MD., 20785 or other t 20e. Method of Disposition 20b. Piece of Disposition (Nama of 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete MD NAT'L MEM PK CEMETERY 12/22/99 LAUREL, MD. permit. Pege Department of Important: If any Injury or 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Name end Address of Fecility JOHN T. RHINES CO., INC. 3030 12TH ST NE, DC 20017 (CLAC 23a. Part / Enter the disease, or complications that call the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each the Approximete intarvel Betw Onset end Deeth **Physician** Immediete Ceuse (Finel diseese or condition rasulting in death) /Medical CVA (STROKE) Examiner Due to (or as a consequence of): Examiner **buriel-trensit** Attanding Physician: The law requires thet the death certificete be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Undarlying Ceuse (Disaase or injury that initiated evants resulting in deeth) Lest and Due to (or es e consequence of): P.O. Box 68760. physician Physician/Medical the Due to (or es e consequence of) signed by the e Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? CHRONIC ATRIAL FIBULLAR/CVA(STROKE)PACEMAKER, RENAL FAILURE Yee 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Were autopsy findings aveilable prior to completion of cause of daath? 24e. Wes en eutopsy performed? page 2 should Completed 2 XNo certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No director 25. Wes case referred to medical Be 26. Place of Deeth (Check only ona) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Deeth 28d. Dascribe how injury occurred 28e. Data of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? After 5 Panding investigation s efter death. 1 Yes 2 No 2 Accidant filled in by the 3 Suicide 6 Could not be determined 28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicida ò To the Hospital of within 24 hours e To the Funeral D Hospital Medical 29a, Certifier 1 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the causa(s) and manner as stated.

2 Madical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end manner stated. pletely 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/17/99

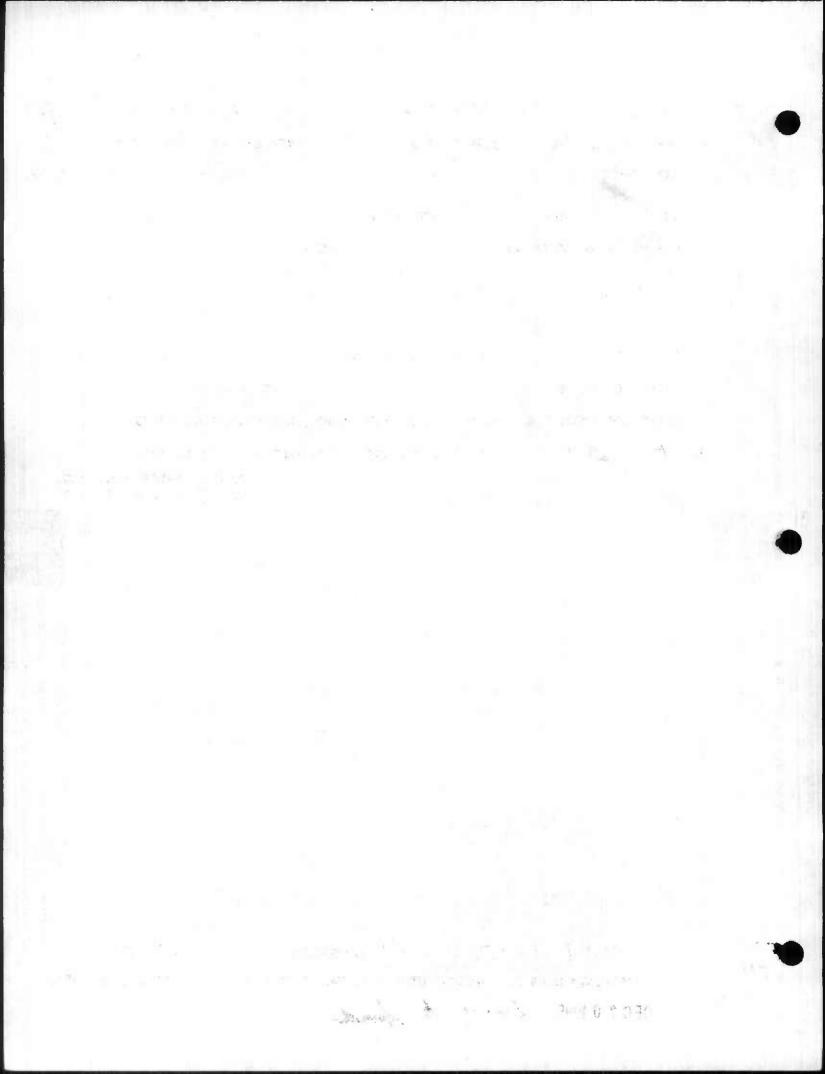
31. Dete filed (Month, Day, Yeer) State DEC 2 0 1999 Registrar



30. Neme end eddrass of person who completed cause of deeth (itam 23a) (Type, Print)

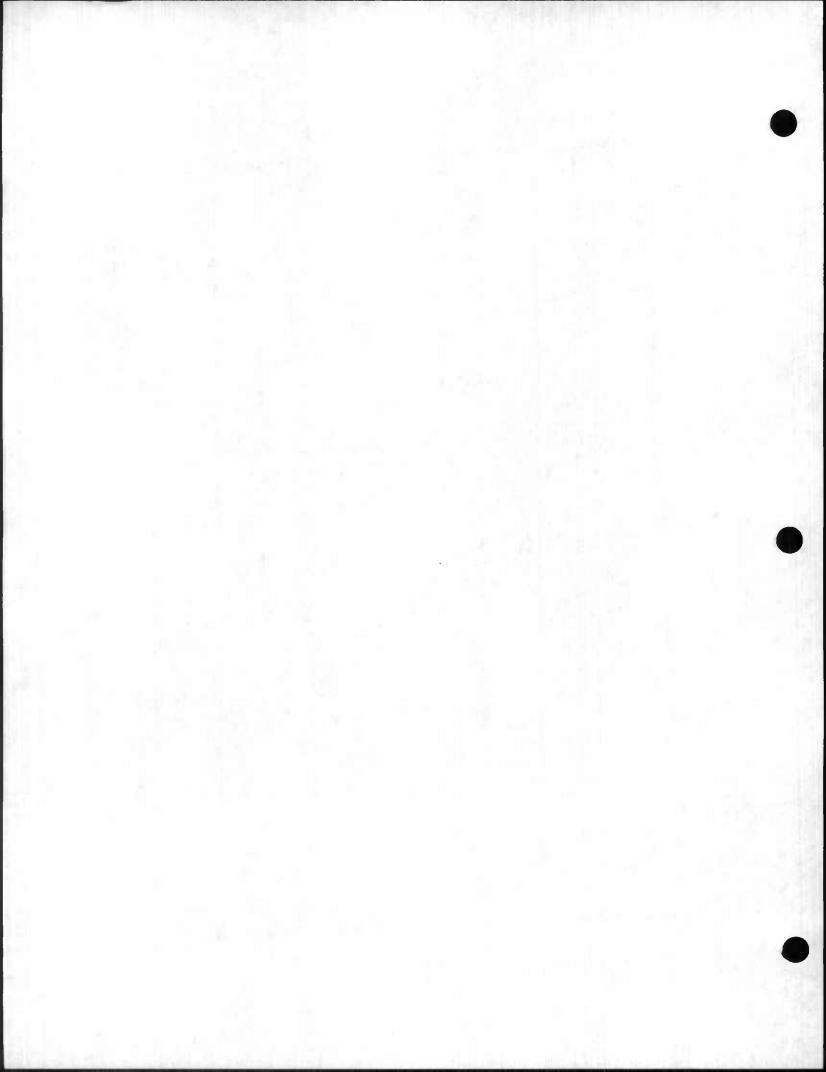


D-0003396



VOID
CERTIFICATE #
29-41204_
SEE

SERTIFICATE NO SETAL DEATH



Ple

Plea	ase Type or State o		d / Depa	artment of	Health and			ible.	1905			
			Cei	rtificate o	f Death		Reg. No.					
1. Decedent's Neme (First, Midd	lle, Last)		-			2. Dete of De	eth	3.	Tima of Death			
Warren Arthur W	Wheeler, S	r.				DECEMB	ER 21,	1999 9	:25 A.M.			
4e. Facility Neme (If not institution	on, give street and nur	m <i>ber)</i>			4b. City, Town, o	r Location of Deat	h 4c. Count	y of Death				
Malcolm Grow A	AAFB Hospi	tal			Camp Spr	rings	Princ	e Georg	e's			
5. Sociel Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Ye			th Voss	9. Birthplece	(State or Foreign			
054 44 6919	1 □MM 2 □ F	47	Yrs.	Months Dey	ys Hours Mi	Octobe	r20,195	2New Yo	rk, NY			
Usuel Residence of Decedent												
10e. Stete 10b. County	/	10c. Cit	y, Town or Lo	ocation					nside City Limits			
Maryland Prince	e George's		Suitla	ınd				1	Yes 2 No			
10e. Street end Number				10f. Zip Code	Э		10g. Citizen of	Whet Country?				
4516 Maple Road	i			207	46		USA					
11. Menitel Stetus	12. Wes Dece Armed Fo	edent Ever in U	S. 13.	Wes Decedent of	of Hispenic Origin?	(Specify Yes or No		ce - Americen II	ndien,			
1 ☐ Never Merried 2 ☐ Mar	ried 1 Ves	2 🗆 No				ono rican, etc.)		eck, White, etc.				
3 Widowed 4 Divorced	ars	1□Yes 21☑N	lo Specify:		Specia	^{by:} Black	lack					
	nt's Educetion est grade completed)		16e. Dece	dent's Usuel Occ	supetion ne during most of w	vantria a	16b. Kind of E	Business/Industr	у			
Elementery/Secondery (0-12)	College (1	I-4or 5+)	life.	DO NOT use ref	ired)	OTKING						
	2		Compu	iter Man	ager		United	States	AirForce			
17. Father's Neme (First, Middle,	Last)				18. Mother's N	eme (First, Middle	, Meiden Sume	me)				
Wendell Wheeler	:				Lottie	e Matthis	3					
19e. Informent's Name/Relations Shirley A. Whee					Road Suit			n, State, Zip Coo	fe)			
20e. Method of Disposition 1 XBurlal 2 Cremetion 4 Donetion 5 Other (S		Stete	lece of Dispo emetery, crer	esition (Neme of metory or other p	olece)	Dete		- City or Town,				
21. Signeture of Funerel Service	C. Bus	ca 10	m ()	2. Name end Add	dress of Fecility MA	ARSHALL'S	FUNERA	L HOME	8			
23a. Part1. Enter the disease, o shock, or heart teilure. List	r complications that c t only one cause on e	aused the deetl ech line.						App	proximate prvel Between set end Death			
Immediate Ceuse (Finei disease or condition resulting in death)	e. METAS	METASTATIC NON-SMALL CELL LUNG CANCER										
		Due to (a	r es e consec	quence ot):								
Sequentielly list conditions, if any, leading to immediate	6	Due to (o	r es e consec	quence ot):								
cause. Enter Underlying Cause (Diseese or injury	с											
thet Initieted events resulting in deeth) Lest	l,	Due to (or es e consequence of):										
Pert II. Other elgnificant condition	One contributing to de	eath but not resu	ulting in the u	nderlying cause	niven In Pert I	23h Did	tohacco usa ci	ontribute to the	cause of death?			
					groom		Yes 2□ No		y 4 Unknown			
						24e. Wes	en eutopsy omed?	evelleb	utopsy findings le prior to tion of ceuse h?			
						1 🗆	Yes 2∏No	1 □ Ye	s 2 No			
25. Wes cese reterred to medica examiner?	il				26. Plece of D	eeth (Check only	one)					
1 Yes 2 XNo	Hospitel: 1 🗆 I	npatient 2 🖔	ER/Outpetier	nt 3 DOA	Other: 4 Nursing	Home 5 ☐ Resi	dence 6 🗆 Ot	her (Specify)				
27. Menner of Deeth *XXNetural 5 Pendir 2 Accident Investi	28e. Dete d (Mont		28b. Time of Injury	V			how injury occu		17			
3 Sulcide 6 Could 4 Homlcide determ	not be nined 28e. Plece buildin	of Injury - At hong, etc. (Specif)	ome, ferm, str	eet, factory, offic	28f. Location (Street and Number or Rural Route Number, City or Town, State)							

permit. Peges 1 end 2 should be tiled within 72 hours efter death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fnjury or other traumatic event, the Med cal Examiner must be notified at Baltimore, Maryland 21215-0020 Division of Vital Records, P.O. Box 68760.

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

10

Funeral

Director

29a. Certifier (Check only one)

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and ettending physician and for use as the bunal-transit Physician/Medicai s certificate has been signed by the director, page 2 should be detached Completed by After this certificate funeral director, pag Be 10 Certification:

completely filled in by the Medicai State

31. Dete tiled (Month, Dey, Year) **DEC 2 3** 1999

30. Neme end address of person who ROBERT DONEGAN,

completed cause of deeth (Item 23e) (Type, Print) 89 MDG/ 1050 W PERIMETER RD USAF, MC 33. Registrer's Signeture

1 🖰 Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number

MD 057546-L

29d. Dete signed (Month, Day, Year)

DECEMBER 21, 1999

ANDREWS AIR FORCE BASE, MD 20762-6600

Registrar

CECCA SE SAME SECTION OF SECTION

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Physician			(First, Middle, La		RSP001						. Date of Dea Month	neg. No. th Day ER 19,	Year 1999		of Death
/Medical Examiner				ve street and number ROAD APA		r # 4			ib. City, Too MOUNT	wn, or Loca	tion of Death	4c. County			
uneral	28	ial Security Nu 1-44-17	709	Sex 7	Sallist sall	last birthday) 51 Yrs.	If Under Months	1 Year Days	If Under a	Min.	8. Dete of Birth (Month, Day, Year) Nov. 15, 1948 (Columbus, OH				
'naturel' or flams 23s or 28s-f show edical Examinar must be notified at letted by Funeral Director	10a. S	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD PRINCE GEORGE'S MT. RAINIER								10d. Inside City 1 □ Yes					
	10e. S	10e. Street and Number 10f. Zip Code 2904 BUNKER HILL RD # 4 20712									10g. Citizen of V				
	3 [arital Status Never Married Widowed 4	d 2 Merried	Armed Force 1 Yes 2	/es Decedent Ever in U,S. med Forces? 13. Was Decedent of Hispanic Origin? (Spring Yes, specify Cuban, Mexican, Puerto				in? (Speci Puerto Ri	city Yes or No- lican, etc.) 14. Race - American Indian, Bleck, White, etc. Specify: BLACK					
en, presented	Eler	(Specify	15. Decedent's E y only highest gr dary (0-12)	ducation (Give kind of work done during most of life. DO NOT use retired) College (1-4or 5+) INSPECTOR				of working	orking 16b. Kind of Business/Industry CONSTRUCTION						
To Be C	17. Fa	ther's Name (F AWRENCE	First, Middle, Las WADE	")							ne (First, Middle, Maiden Sumame) V. RIDDLE				
other treumstic event,	19a. li	19a. Informent's Name/Relationship (Type, Print) L. MIACHEL WADE 19b. Meiling Address (Street and Numb 222 GRAFTON AVENU							Pural Route Number, City or Town, State, Zip Code) DAYTON, OH 45406						
in-transit and process and injury or grammer Examiner	23a. F	Pert1. Enter the shock, or heart diate Cause (Fise or conditioning in death)	feilure. List only	pplications thet cause on each	Due to (c	h. Do not ent	er the mod	Isla		e. Mt	. Rain	neral Hoier, MD	207		etween
use as the bur	Cause that in resulti	entially list cond leading to imm Enter Underly (Disease or in itiated events ing in death) La	ast	d		r es e consequence es e		euse giv	en in Pert I.		23b. Dld 1	obacco use co	ntribute to	the caus	of dea
be deteched for use as the bur by Physician/Medical	Cause that in resulti	ing in death) La	ast	d				euse giv	en in Pert I.		1 🗆 1	/es 2□ No	3 Prob	re autops	y linding
page 2 should be deteched for use as the burnel of the bur	Cause that in resulti	other eignific	ant conditions	d				euse giv			24a. Wes operfor	en autopsymed?	3 Prob	re autops illable pro npletion of leath?	y linding
is certificate has been signed by the estending physicial director, page 2 should be deteched for use as the but To Be Completed by Physician/Medical	Cause that in resulti	ing in death) La	eant conditions of	d	but not rese		nderlying c	Oth	26. Place		24a. Wes perfor	en autopsymed?	3 Prob	re autops illable pro inpletion o leath?	y linding or to f cause
instruct. After this centificate has been signed by the ettending physical in by the funaral director, page 2 should be deteched for use as the burnification: To Be Completed by Physician/Medical	Part II.	other signific as case referre	eant conditions of	Hospital: 1 ☐ Inpe 28a. Date of Ir (Month, I	but not resi	ER/Outpaties 28b. Time o Injury	nderlying c	Oth DA Oth PBc. Injur Wor	26. Place	rsing Home 28	24a. Wes operform	en autopsymed? Ves 2 No No Nence 6 Otherwise injury occurrence and Number	3 Prob	re autops illable pricipion o leath?	y linding or to f cause
is carificate has been signed by the estending physicia director, page 2 should be deteched for use as the bur Io Be Completed by Physician/Medical	Part II. 25. We explain the second of the s	as case referre armine? Xes 2 Netural Acident Suicide Homicide	ant conditions of the conditio	Hospital: 1 ☐ Inpe 28a. Date of Ir (Month, I	tient 2 [] ijury lay Year) njury - At hetc. (Specification of examinal	ER/Outpatier 28b. Time of Injury ome, ferm, str	nderlying c	Oth Oth Wor Upor Upo	26. Place er: 4 □ Nu y at k? Yes 2 □ I	rsing Home 28 No 28	24a. Wes a performance of the control of the contro	en autopsy med? les 2 No ne) lence 6 Oth low injury occurr Rirect and Numb m, State)	3 Prob 24b. We ave cor of cor (Specify) red cor Flura	re autops illable prior pletion o leath? Pres 2 Proute Millable Millable prior pletion o leath?	y linding or to

DHMH 16 Rev 6/95

2001 2036 James 2036

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day HAZEL WALKER DECEMBER 15, 1999

4b. City, Town, or Location of Death 4c. County of Deeth 9:50pm 4e Fecility Neme (If not Institution, give street and number) GLADYS SPELLMAN NURSING CENTER CHEVERLY
If Under 24 Hrs. PRINCE GEORGES 8. Date of Birth 9. Birthplece (State or Foreign Sept. 20,1930 Wash. D.C. 5. Social Security Number 7. Age (In yrs. last birthday) Deys 1 M 2 XF Months Hours Min. 69 Yrs. 578-38-9709 Usuei Residence of Decedent 10e. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Washington D.C. 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1221 M St., N.W. #527 U.S.A. 14. Rece - American Indien, White, etc. 20001 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1□ Yes 2No Specify: Specify: Black 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) None 6th None 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) Bennie Walker Josephine Livingston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Cynthia Jones 200 K. St., N.W. #801 Wash. D.C. 20001 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete MBuriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Harmony Memorial Park 12/23/99 Landover, Md 22. Name and Address of Fecility 21 Signature of Funeral Service Licensee Johnson & Jenkins Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.

A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest.

A 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate intervel Between Onset and Death Immediate Cause (Finel a. Congestive Heart

Due to (or as a consequence of): disease or condition resulting in death) Acute Renal Resperoutery 1
Due to (or es e consequence of): Anoxic encephalopathy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy History of Colon Canar 27 No 1 TVes 2 No. 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred

Physician /Medical Examiner

ed by the e

signed I

certificate

this

aftar daath.

To the Hospital e within 24 hours a To the Funeral D

funeral director,

completely

or Attending Physician:

by

Completed

Be

2

Medical

29a. Certifier

Division of Vital Records, P.O.

Department of important: If any injury or pace.

Physician

/Medical

Examiner

Director

Funeral

p

Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f shor traumstic event, the Medical Extension must be notified at

nit. Peges 1 and 2 should be filed within sartment of Haaith end Mentai Hygiena. ortant: If item 27 is marked other than "Injury or other traumatic event, the Mas.

Baltimore,

with the Maryland

death

72 hours after

Examiner physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Physician/Medical 88 USB

Diabeles

Hyperternion

25. Was case referred to medical examiner?

1 Yes 2 No 27. Manner of Deeth 1 Natural

2 Accident 3 ☐ Suicide 4 ☐ Homleide

5 Pending investigation

6 Could not be 28e. Ptaca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29b. Signature and title of cartifier Nan of Kalpana Frandty

20052848

29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) NANCY K. 5801 ANNAPOUS RD

HYATTSVILLE

Registrar

31. Date filed (Month, Day, Year)





DHMH 16 Rev 6/95

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Cortifying Physicien: To the best of my knowledge, deeth occurred at the time, dete and placa, and due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29c. Licanse number

OEC 2 2338 Johnson M. Samuel

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #10e, 19b, 12/26/99, BMW, Montg.Co. Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Tima of Death 2. Dete of Death **Physician** DEC. 20, YOUNG-JAHALAL 1999 8:30 AM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park MONTGOMERY 8. Date of Birth (Month, Dey, Year) Feb. 5,1941 If Under 1 Year if Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Deys 1 M 2 XF Hours 212-04-2154 58 Director Jamaica Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery 1 Yes 2 No Director Silver Spring 28a-f 10e. Street and Number Osage 10f. Zip Code 10g. Citizen of What Country? 8 1018 Old Sage Street 20903 U.S.A. Nerns 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2€ No If Yes, Give 14. Race - American Indien, 11. Meritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 72 hours after 1 ☐ Never Merried 2 Married 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐XNo Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) 9 th College (1-4or 5+) Seamstress Dept. Store 17. Fether's Neme (First, Middle, Last) 18 Mother's Neme (First Middle Maiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental H ant: If hem 27 is marked off jury or other traumstic even Be Alexander Young Doris Christian 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 20903 Wilson L. Jahalal (Husband) Old Sage St., Silver Spring, MD 3818 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete George Wash. Cem. 12/23/99 Aldephi, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service License 22. Name end Address of Fecility
SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850 Part 1. Enter the direese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Causa (Finel disease or condition resulting in death) 24 hrs Hepatic Failure Examiner Due to (or es e consequence of): Examiner Metastatic Colon Cancer 6 mos sician and burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): Box 68760, physician s the buria Physician/Medical Due to (or es a consequence of): 98 eşn signed by the a d be detached f P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24a. Wes en eutopsy performed? 24b. Were autopsy tindings available prior to Completed completion of cause of death? page 2 hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: director. Be 25. Wes case referred to medical axeminer? 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Menner of Deeth 28d. Describe how injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? or Attending 5 Panding deeth. 1 Yes 2 No investigetion 2 Accident 24 hours after deel Funeral Director: 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 2 4 Homicide filled in Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner as steted.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steted. Medical 29a. Certifier completaly k only

within 2 6 State

ę,

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) 7525 Greenway Ctr.Dr., Greenbelt, MD 20770 Martin D. Weltz, M.D.

31. Dete filed (Month, Dey, Year) **DEC 23** 1999

Martin

19b. Sip

32. Registrer's Signeture

Weltzu

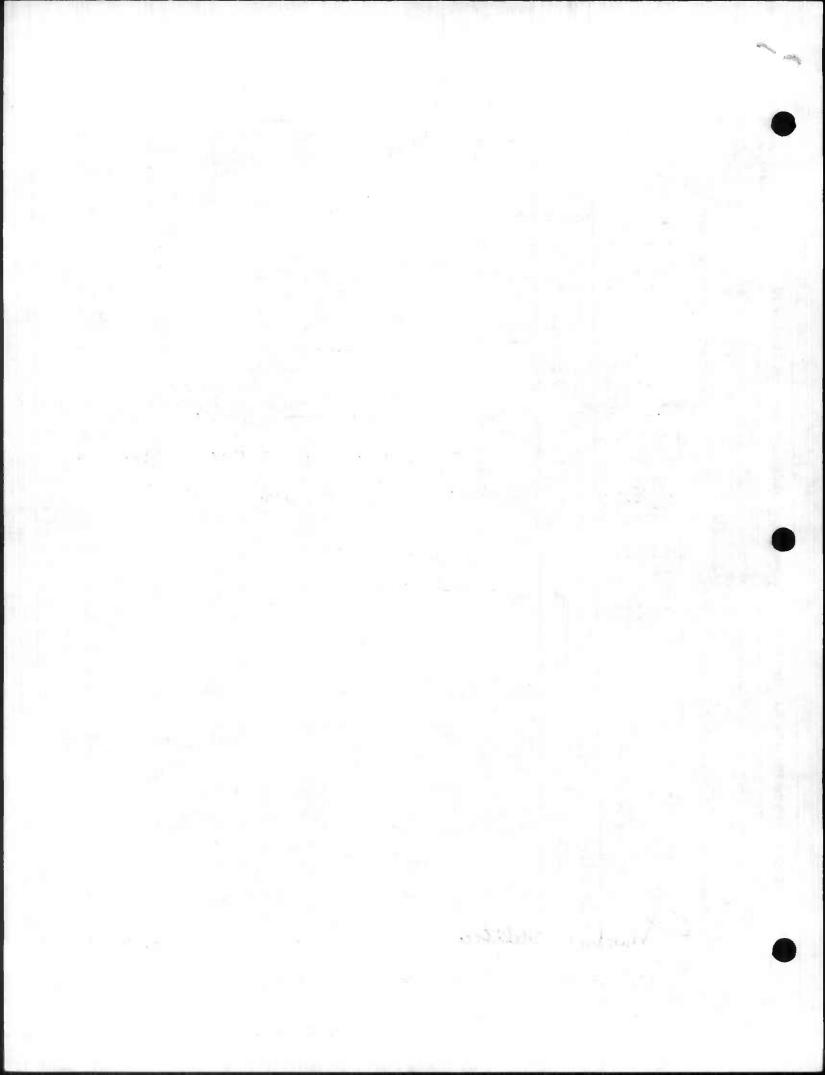
29c. License number

D23743

29d. Date signed (Month, Day, Year)

Dec. 20, 1999

Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Yoon -Onn Yik December 21, 1999 ation of Death 4c. County of Death 12:30 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Southern Maryland Hosptial Clinton If Under 24 Hrs. Prince George's If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Min. Months Hours 1 M 2 F 217 02 5349 Nov 20, 1915 China Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits P.G. Clinton 1 ☐ Yes 2 No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 8309 Bellefonte Lane 20735 China 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 27 Vo If Yes, Give Vo Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 DyNo Specify: Specify: Oriental 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 6th Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Yik Lee Ho 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (SON) 8309 Bellefonte Lane, Clinton, Maryland James Kong Wing Low 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) Jan 3, 2000 20a. Method of Disposition 20c. Location - City or Town, Stata 1 DiBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National Cemetery Suitland, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facilityee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 Wan 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocaupik disease or condition resulting in death) Due to (or as a consequence of) DINDINGLI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Anpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2X No 27. Menner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending

1 Tyes 2 No

SURRAHS

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

MD

Director

Funeral

P

Completed

Be

Funeral

Director

"natural", or frame 23a or 28a-f show

the Medical

traumatic event,

the Maryland

death

filed within 72 hours after

nd Mental Hygiena. marked other than

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked other any Injury or other traumatic event once.

21215-0020

Baltimore, Maryland

ician and burial-transit The law requires that the death certificate be executed physician s the burial Box 68760. 88 980 for signed by the a d be detached f P.O. Records. page 2 s of Vital Physician: this Affer Division

Physician/Medicai

þ

Completed

Be

Certification: To

edical

or Attending after death. 3 .5 filled bellin

To the Hospital within 24 hours a To the Funeral C completely filled

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month. Day. Year)

29b. Signature and title of certifie

2 Accident

3 Suicide

29a. Certifie (Check only

4 Homicide

completed cause of death (Item 23a) (Type, Print)

DEC 2 3 1999

investigation

6 Could not be determined

32. Registrar's Signeture

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

DEC 2 2 again

200 A4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** December 20 1999 1314 Peng Zhao /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE
If Under 24 Hrs. 8. Dail MONTGOMERY If Under 1 Year Months Days 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) **Funeral** 10M 20F Months Hours 79 Director n/a Sept. 21,1920 Rep. of China Usual Rasidence of Decedant the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 ☐ Yas 2 ☐ No Director North Railroad Sta Cheng Du, Sichan 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Berne 23a #1 West Avenue Republic of China n/a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas ②XNo If Yas, Giva Yaar or Datas: 14. Race - American Indian, 11. Marital Status "natural", or Itam adical Examiner. Black, Whita, atc. filed within 72 hours after Hygiene. ther than "natural", or its 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas XX No Specify: Chinese Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Collega (1-4or 5+) permit. Pages 1 and 2 should be filled w.
Department of Health and Mental Hygien, important: if Item 27 is marked other tha any Injury or other traumatic. 0 0 Driver Railroad 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be Unknown Unknown 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) Yi Xiu Zheng / Wife #1 West Ave., Cheng Du, Sichan, China 20b. Plece of Disposition (Nema of cematary, crematory or other place) 20a. Mathod of Disposition Deta 20c. Location - City or Town, Stata 1 ☐ Burial 2 XCramation 3 ☐ Ramoval from Stata Dec.21 Chesapeake Crematory Inc. 1999 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 21. Signatured Funeral Survice Library

22. Nama and Address of Facility
Rapp Funeral and Cremation Services
Stephen D. Lohrmann P.A.
933 Gist Ave., Silver Spring, MD 2

23a. Part1. Entartha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 21. Signature of Funeral Se Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final Sepsis 10 Days disaasa or condition resulting in death) Examiner Due to (or es e consequence of): Examiner 10 Days Bacteremia physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760. 10 Days Pneumonia Physician/Medical the Dua to (or as a consequence of): 080 signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? PO 1 Yes 20No 3 Probably 4 Unknown Records, þ The law requires been si 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? certificate has b 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: after death. Director: After this certifice 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Certification: To 1 Yas ZNO 1 ☑ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mennar of Death 28e. Deta of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Invastigation 1X Natural
2 ☐ Accident 1 TYes 2 □ No 6 Could not be datamined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end mannar as stated.

Wedical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steted. 29a. Cartifiar Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and title of cer D0052927 December 20, 1999 2 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) Rockville, MD

DHMH 16 Rev 6/95

State

Registrar

Theodore Gwebe, M.D.,

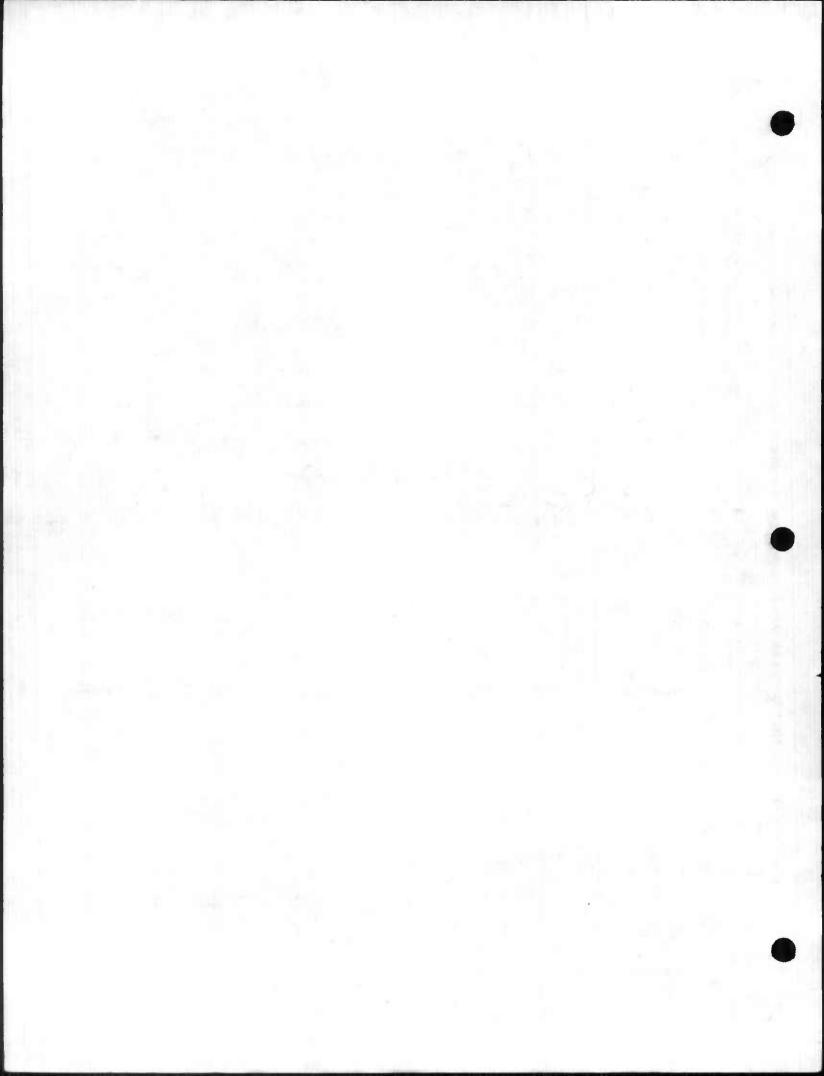
DEC 22

31. Data filed (Month, Day, Year)

32. Registrar's Signatura

Denewa

Shady Grove Adventist Hospital, 9901 Medical Center Dr.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND: #17,20B PER F.H. G780 2-2-2000 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year **Physician** BURLESON KEMP December 29, 1999
cation of Death 4c. County of Death 17:18 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner HOSPITAL IT Under If Under 24 Hrs. B. Date of Birth (Month) Day, Year) 4/24/1962 THE JOHNS
5. Social Security Number 6. Sa HOPKINS 7. Aga (In yrs. last birthday) 6 Sax 9. Birthplace (Stata or Foraign **Funeral** Months Days 100M 20 F Country) Florida 242-21-3441 Director Usual Residence of Decedent 10a Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits NC Davidson High Point PC Yes 2 No Director 288-1 2 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code mast be. ò 709 Dorado Circle 27265 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) **Items** 11 Marital Status 12. Was Decedent Evar in U,S Armed Forcas? 14. Race - Amarican Indian, Black, White, etc. filed within 72 hours after 1 Nevar Married 2 Married 1 ☐ Yes 2√2 No If Yes, Give b Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 20 No Specify: à 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Real Estate Realtor 17. Father's Neme (First, Middle, Last) BOBBY MCRAY BURLESON 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Bob McRea Burleson Betty Robbins 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 709 Dorado Circle High Point NC. 27265 19a. Informant's Name/Relationship (Type, Print) or other trau Mrs. Carey Springs Burleson 20b. Place of Disposition (Wallie of FLORAL GARDEN cometer), crematory or other place)

Highland Memorial PARK CEM 20a. Method of Disposition 20c. Location - City or Town, Stete HIGH POINT NC 9 Bossomer Alabama 1 Burial 2 Cremation 3 Removal from State Department o Important: If any Injury or 12/30/99 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Addrass of Facility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 23a. Part I. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final Weeks ADULT RESPIRATORY DISTRESS SYNDROME disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner BACTERIAL SEPSIS burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of) physician s the burial Box 68760. Physician/Medical Dua to (or as a consequence of): 50 signed by the attending to be detached for use Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown GASTROINTESTINAL BLEEDING Division of Vitai Records. Completed by 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? DUODENAL ULCER completion of cause of death? pege 2 certificate 1 Yes 21/1No 1 Yea 2 No or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yas 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28h Time of 28a. Dete of Injury (Month, Day Year) 28c. fnjury at Work? After 5 Pending investigation 1 Natural 2 Accident e Hospital or Attendin n 24 hours after deeth. e Funeral Director: Aft 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 C Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, streef, factory, office building, etc. (Specify) filled in by 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. Medical 29a. Certifier completely (Check only within 2 9 ATTENDING PHYSICIAN 29c. License number 29d. Date signed (Month, Day, Year) 10 D47312 DECEMBER 29 1999 WAD THD 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) JOHNS HOPKINS ONCOLDBY CTA PAUL V. O'DONNELL, MD PhD BAUTHORE, HOD 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

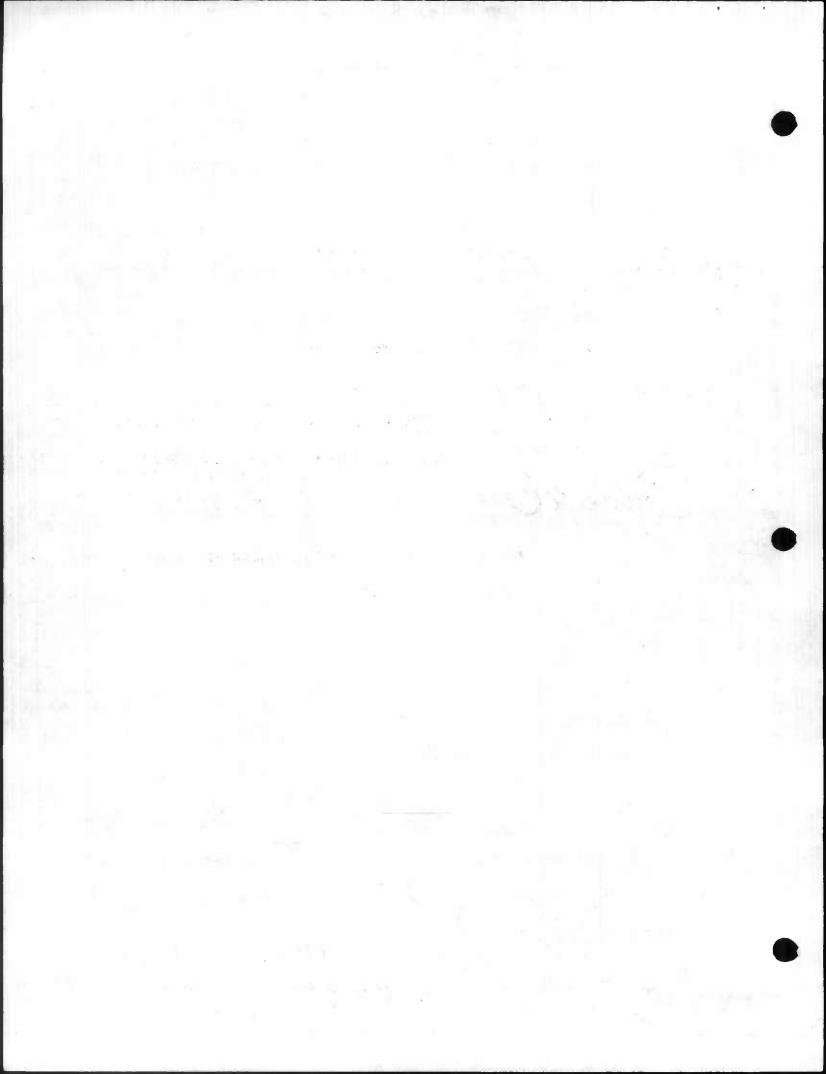
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND #26&28c PER MD. G779 1-7-2000 J.A. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Helen C. Brown 99 18, Dec. 8:35am /Medical 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 720 W. Cherry blossoms Way Baltimore 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 216-32-8855 1 M 2 KF 61 Yrs. Director Usual Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Hadical Examples must be notified at Director MD NA 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 720 W. CherryBlossoms Way 21201 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ₺ No If Yes, Give 14. Race - American Indian, 11. Merital Status Black, White, etc. 72 hours after 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify: natural, or Specify: Black p 3 ☐ Widowed 4 ☐ Divorced Veer or Detes Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry East Baltimore Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Drug Counselor Center Drug . Pages 1 and 2 should be filled wi tment of Heelth and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, the 12th Grade 2yrs. Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emma Vernon Morton 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21201 19e. Informant's Name/Reletionship (Type, Print) William Brown 720 W. Cherry Blossoms Way Baltimore, MD 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete M D 20a. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removel from State permit. Page Department of Important: If any Injury or once. Garrison Forest VA Cem. 12-23-99 Owings Mills 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 of Funeral Service License WM.C.March FH 1101 E. North Avenue 23a-Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final NEGRACIO NON-SMALL COLL CARGINOMA OF the brains diseese or condition resulting in death) Examiner Due to (or as a consequence of) Examiner AND LUNAS HIRR certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): and physician Box 68760 Physician/Medical the Due to (or as a consequence of): for use as 88 P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the 1 Yes 2 No 3 Probably 4 Unknown HYDERTENSION Division of Vital Records. by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed Diabetes Mellinus Type II peeu completion of cause of death? 2 No 1 Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) To Hospitel: 1 | Inpatient 2 | CROutpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 □Other (Specify) this 28a. Dete of Injury (Month, Dey Year) 27. Mapmer of Death 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident or Attending 5 Pending after death. Director: Aft 1 ☐ Yes investigation 6 Could not be determined 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 24 hours after Funeral Dire letely filled in b Hospital 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner intent. edicai 29a. Cartifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifig MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Weekes HRAGHD 22 GREENS STREET DOORTHARK of Molicine Biting, MD MI 32. Registrar's Signatur 31. Dete filed (Month, Day, Year) State 0 Registrar

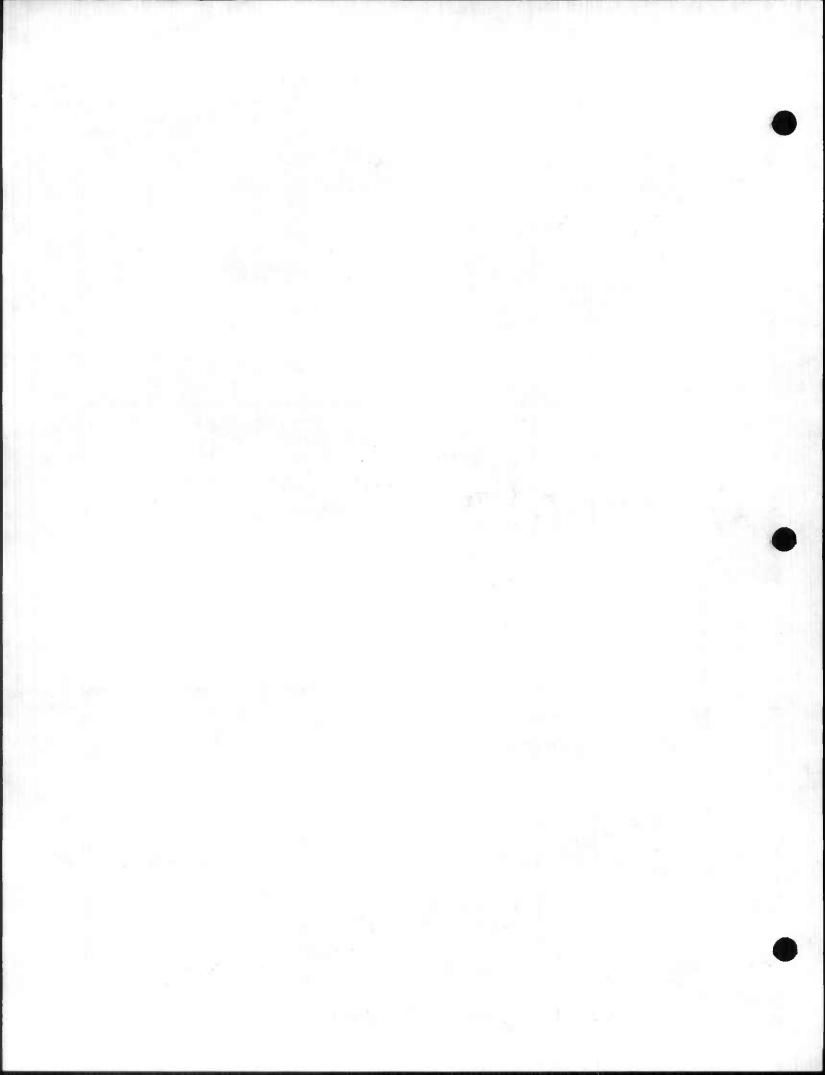
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Physician /Medical Examiner	Stephen Rams 4e Facility Neme (If not institution Johns Hopkin 5. Social Security Number 239-78-5890 Usuel Residence of Deceder	ution, give s		1					Davis .	Maria		
Examiner Funeral Director	Johns Hopkir 5. Social Security Number 239-78-5890					L. F	December 2			9:10A.M.		
Director	5. Social Security Number 239-78-5890	s Host		nstitution, give street and number) 4b. City, Town, or Lo						of Death		
f ehow	Heuni Basidance of Danadar		pital M 2□F	7. Age (In yr	s. last birthday) If Under 1 Yaer Months Deys		er If Under 24		irth lay, Year) 5,1948	9. Birthplaca Country) North Co	a (Stata or Foraign	
de de la	10a. State 10b. Co			10c. 6	City, Town or Lo	ocation					nside City Limits	
* IN #	Maryland Ann	e Arur	ndel		Galesv	ille				1	☐ Yes 2 No	
or 28-1 or 28-1 or Director	10e. Street and Number					10f. Zip Cod	0		10g. Citizen of V	What Country?		
23.e	P.O. Box 256			20765				U.S.A.				
72 hours after death with the Meryland natural, or Hems 23e or 28e-f show offer Exercises must be notified at sted by Funeral Director	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ Divo	Armed F	20 No		Was Decedent of the Vas, specify C	uban, Mexican, P	? (Specify Yas or N uerto Rican, etc.)		a - American In k, White, etc.			
ed within 72 hours ygiene. er than 'natural', f, it a Morical Ex-	15. Deci (Specify only h Elementery/Secondary (0-	completed, College ((1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)				16b. Kind of Business/Industry				
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should be if and Mentel H americal out umetic ever	17. Father's Neme (First, Middle, Last) Boyd C. Campbell, Sr. 18. Mother's Neme (First, Middle, Last) Rosalind C:											
rau rau	19e. Informent's Neme/Rele Gail S. Campb					_		r Rural Route Num ille, Mar	-	Stete, Zip Code 20765	9)	
5 5 5 0	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremel 4 ☐ Donation 5 ☐ Othe		emoval from	Steta	Place of Dispo cemetery, crer etro Cr	metory or other	place)	.30,1999	20c. Location - Baltimo	M 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
permit. Page Depertment of Important: If eny Injury or bhes.	21. Signature of Funerel Ser		· X	1110	22 H	2. Name and Ad ardesty	dress of Fecility Funeral	Home, P.	Α.		21401	
Physician /Medical Examiner	23a. Pert1. Enter the diseas shock, or heart teilure. Immediate Cause (Finel diseasa or condition resulting in death)	e, or complic List only one	e cause on	each line.	pirator	y Distr	dying, such es car ess Synd		arrest,	Ons	roximata rvel Between set and Death WEEK	
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s been 2 shoul	Cryptococca	l Meni	ingiti	.S					s en autopsy formed?	avallabl	utopsy findings e prior to tion of cause 1?	
certificate he rector, page									Yes 2⊠No	t 🗆 Yes	s 2□ No	
	25. Wes case referred to me examiner? 1 ☐ Yes 2 ☐ No	1117	ospital:X	Inpatient 2		- a - Doa	Other	Death (Check only		(C4.)		
	27. Manner of Death 1* Detural 5 □ Pe	nding estigation	28a. Date		28b. Time of Injury	28c. t	njury et Nork?	ng Home 5 ☐ Res 28d. Describe	how injury occur			
x25c 1	3 ☐ Suicide 6 ☐ Co 4 ☐ Homicide de	uld not be ermined						City or To	(Street and Numb own, Stete)			
To the Hospital of within 24 hours at To the Funeral D completely filled i	29a. Certifier (Check only one)	fying Physical Examine	er: On the b	e best of my ki pasis of exami oner stated.	nowledge, death nation and/or in	n occurred at the vestigation, in m	e time, date end p ny opinion, death o	lace, end due to the occurred at the time	e cause(s) and me o, date and place,	enner as stated and due to the	cause(s)	
within To the comp	29b. Signature and the of on	tifier				29c. Lic	ense number		29d. Date signe	d (Month, Day,	Year)	
25	30. Neme and address of page	AUD	noleted cau	se of death /li-	em 23a) (Tune		S-000 600 N. W	olfe Stre	December	29, 19	999	
8					ns Hosp			e, Maryla		37		

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Dev Month Paul Dennis DiFelice 4b. City, Town, or Location of Death 1999 11:02 PM 4c. County of Death 4a Facility Name (If not institution, give street and number) Saint Joseph Medical Center Baltimore Towson W Under 1 Year | W Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10 M 20 F Days 374-50-8923 8-19-1946 Michigan Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Q,Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3407 Mary Ave. 21214 S. A. 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give⁵ Year or Dates: 14. Race - American Indian, Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bleck, White, etc. Never Merried 2☐ Merried 1 Yes 2 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) UNKNOWN N/A 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Meiden Sumame) Arnaldo DiFelice Ida Natone 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Mrs Barbara Franks (Sister) 16203 Villa Del Norte, Houston, Texas 17073 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Date 1 ☐ Burlal 2 ☐ Cremetion 3 ☐ Removal from Stete Hilltop Service Corp. 4 ☐ Donetion 5 ☐ Other (Specify) 1-3-00 Towson, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck Inc. 2/3 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one ceuse on each line.

23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE RESPIRATORY DISTRESS SYNDROME Due to (or as a consequence of): SEPSIS Due to (or es e consequence of): Due to (or es a consequence of): 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?

Physician /Medical Examiner

attending physician and for use as the buriel-trans

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Baltimore.

Box 68760.

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Records,

Division of Vital

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Funeral

by

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical that initiated events resulting in death) Last

Pert ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. LIVER FAILURE

RENAL FAILURE

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Death 1 Natural 5 Pending Investigation

2 Accident

29a. Certifier (Check only one) Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury

26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how Injury occurred 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certified

29c. License number D 30263

29d. Date signed (Month, Day, Year)

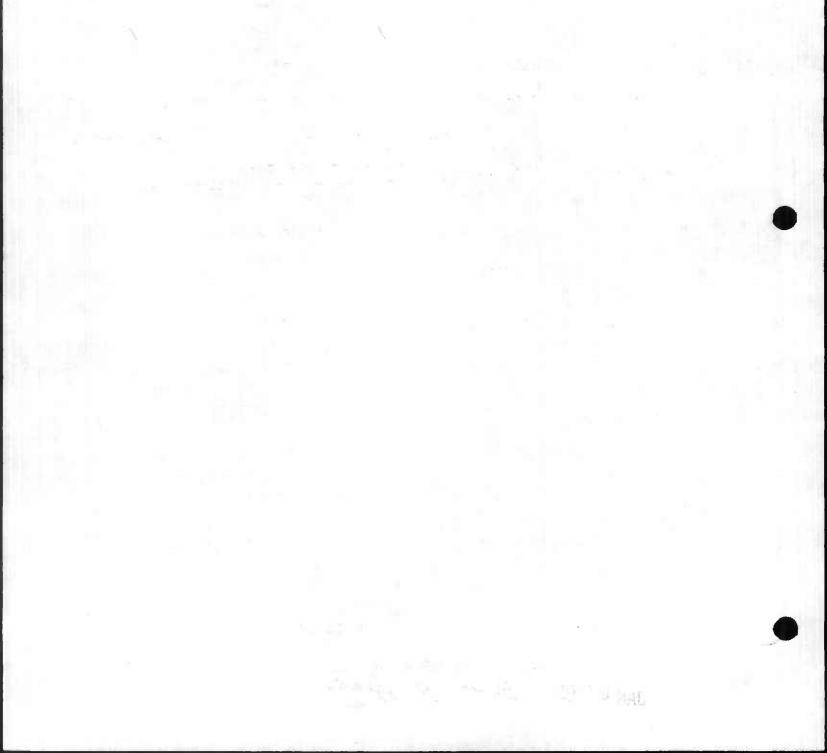
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, M.D., 7601 OSLER DRIVE, TOWSON, MARYLAND

State Registrar

31. Date filed (Month, Dey, Year) 32 Registrer's Signeture 072000

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WRC 99-7744-510 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. ABELL State of Maryland / Department of Health and Mental Hygiene O FULTON AMEND#10F & Certificate of Death AMEND#10e PER F.H. G779 1-7-2000 J.A. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death Month Day
DECEMBER 23, **Physician** 1999 10:00PM. /Medical 4b. City. Town, or Location of Death 4c. County of Doubt 4a Facility Nama (If not institution, giva street and number) Examiner 2126 E. ORLEANS ST. BALTIMORE 6. Sex. 1 △ M 2 □ F If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. tnside City Limits 10a, State 1 Yas 2 □ No Funeral Director Varulance 2126 E. ORLEANS 10f. Zip Coda 10g. Citizan of What Country? 10e Street and Number 21231 ò 2/2/2 23 0 14. Race Race - American Indien Black, Whita, atc. 12. Wes Decedant Evar in U.S. Armed Forcas? Wes Decedant of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Maxican, Puerto Rican, atc.) or Mems 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yas, Giva 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Datas: neturel. 16a. Decedant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) ga (1-4or 5+) 17. Father's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maldan Sumama) Be Peges 1 and 2 should be nent of Health and Mental 19a. Informapt'e Name/Retationship (Type, Print) (Sister 19b. Mailing Addrass (Street and Number or Ryral Routa Number, Stata, Zip Code) or other tra MOSE 20b. Place of Disposition (Neme of 20c. Location - City or Town, Stata Deta 20e. Mathod of Disposition tery crematory or other place 1 Burial 2 Cremation 3 Removal from Stata Department in important: If any injury or other 4 Donation 5 ☐ Other (Specify) 21. Signature of Funaral Service Licenses 22. Name end Address of Facility 40 -une Joseph 2222 216 W. North 23a Part I Enter the greens, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart tallure. List only one ceuse on each line. Approximata tritarval Between Onsat and Death Physician /Medical Immediate Causa (Final Ta disaasa or condition rasulting in death) Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760. the Due to (or es e consequence of) 200 detached Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, Completed by 24b. Ware autopsy findings 24a. Was an autopsy available prior to completion of ceusa of death? page 2 1 ☐ Yas 2 ☐ No 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No Certification: To this 27. Manner of Death 28b. Tima of 28d. Dascribe how injury occurred After Division 5 Pending investigation Injury 1 Natural after death. 1 Tas 2 Accident 12mme/123/98 2/152 3 Suicide 281. Location (Street end Number or Rural Routa Number, City or Town, State) 2 (2 6 0 1 2 4 6 6 Could not be 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) completely filled in by 4 Homicide 2126 Orleans veidence A Balta within 24 hours a Hospital 1 Certifying Physician: To tha best of my knowledga, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) 29a. Certifiar Medical and mannar stated. To the

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31. Date filed (Month, Day Year) Registrar

Mikey Hagistuar's Signatury

(ttem 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

29c. Licanse number

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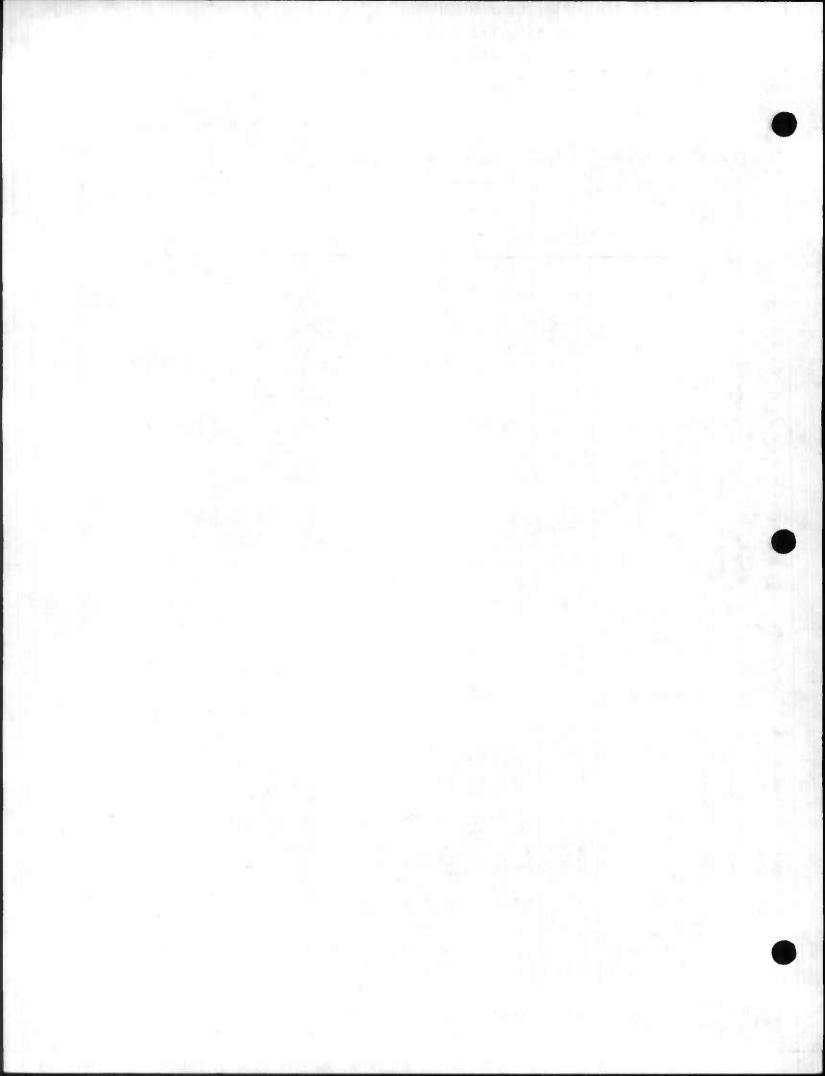
29d. Data signed (Month, Day, Year)

DECEMBER 24, 1999

29b. Signature and titla of certifier

Menday 30. Name and address of person who completed ceusa of

THEN NOME



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month Day GILES SR. WILLIAM 26 1999 20:24 Dec. 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death University of Maryland Medical System Baltimore If Under 1 Yaar Months Days 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplaca (State or Foraign Country) Months XXM 2DF Hours 220-14-1769 73 NOV 29,1926 SOUTH CAROLINA Usual Rasidence of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits MYes 2□ No MARYLAND BALTIMORE 10g. Citizan of What Country? 10e. Street and Number 10f. Zip Code 1224 RANKIN PLACE USA 21223 12. Was Decedent Evar in U,S. Armed Forcas? 1 XYas 2 No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: AFRO AMERICAN 3 Widowed 4 Divorced Yaar or Datas: 50-52 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Elementery/Secondary (0-12) College (1-4or 5+) TRACKMAN 10 RAILROAD CO. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) CLYDE REDDON IVENELL REDDON 19e. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) NORA M. GILES WIFE 1224 RANKIN PLACE, BALTIMORE, MARYLAND 21223 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) CROWNSVILLE V. A. CEM. 12/30/99 CROWNSVILLE, MD. 22. Nama and Addrass of Facility ESTEP BROTHERS FUNERAL SER, P A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart reduce. List only one cause on each line. 21217 MARYLAND Approximata Intarval Batween Onsat and Daath Immediate Causa (Final disaesa or condition rasulting In death) Cancer Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immadiata cause. Enter Undartying Cause (Diseasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably Allnknown 1 Yes 2 No 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yas 2 No 1 Yas 25. Was casa rafarred to medical axanginar? 15 Yas 2□ No 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 2 €R/Outpatient 3 □ DOA 1 Inpatient 27. Menner of Death 28a. Data of Injury (Month, Dey Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending 1 Yas 2 No 2 Accident invastigation 6 Could not be determined 3 Suicida 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, fectory, office building, atc. (Specify) 4 Homicide

physician and the burial-transit that the death certificate be executed Box 68760. attending for use as P.O. detach Records, The Division of Vital peptial or Attending Physician: hours after death. Ineral Director: After this certific funeral in 24 hou. the Funeral Direction of the Hospital To the Hosp within 24 ho To the Fune completely fi

Physician

/Medical

Examiner

Funeral

Director

show

288-1

9 Items 23a

I Hyglens. Other than "natural", or Item

Pages 1 and 2 should be filled hent of Health and Mental Pygis int; If Item 27 is marked other

saffment of Health important: If Item 27 is any injury or other 905s.

Physician /Medical

Examiner

Examine

Physician/Medical

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Completed

Be

To

Certification:

Medical

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

Be

29e. Certifier (Check only one)

29b. Signature and title of certifier

1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, deta and place, end due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

mo causa of death (Item 23a) (Type, Print) address of person who comple

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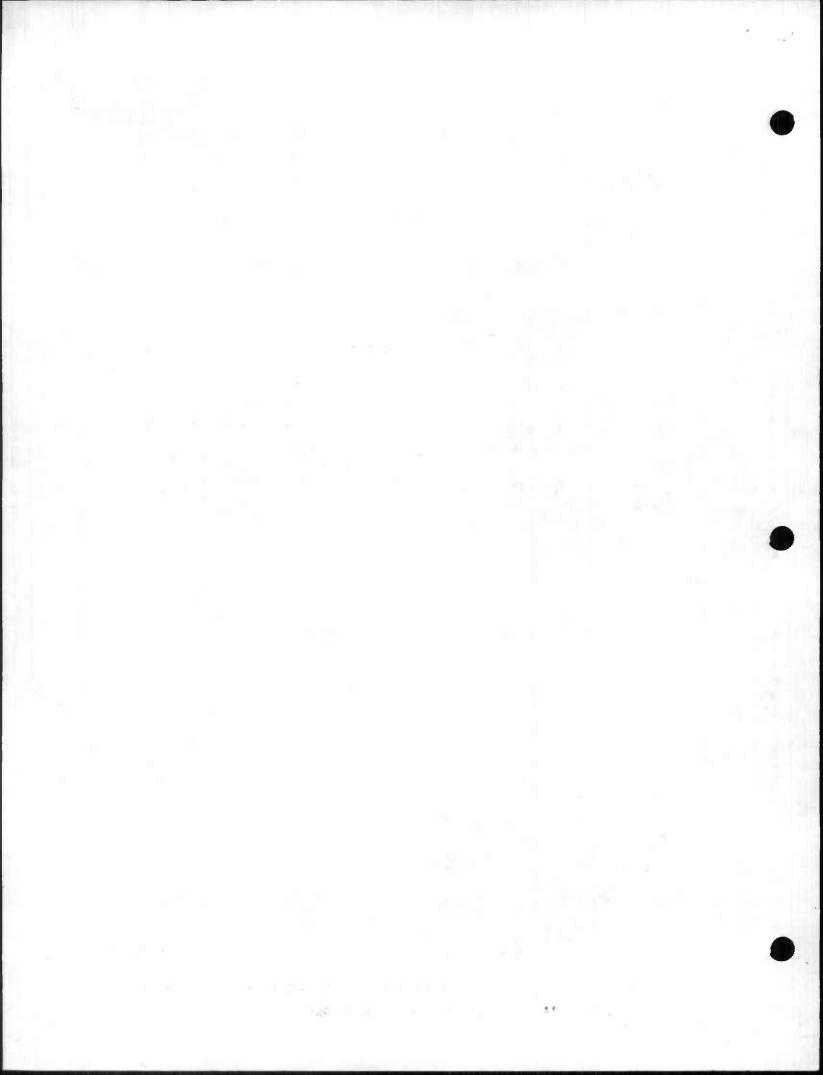
12-31-99

MD 419 W REDWOOD ST. BACKMORE, MD 21201 ADAM J. GEROFF

7 2000 31. Data filed (Month, Day,

32. Registrar's Signatura

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

AMEND##26 P	State of Marylan ER MD. #7,10e&17 PER F.H. G779 1-7-2009	d / Department of Health and Me A. Certificate of Death	ental Hygiene
Physician	Decedent's Name (First, Middle, Last)	2	2. Date of Death Month Dey Year
Physician /Medical	ELIZABETH LOUISE HALL-MILL		DECEMBER 30 1999 3:10 AM
Examiner	4a Facility Name (If not institution, give street and number) 3232 MAGNOLIA AVE.	4b. City, Town, or Local Baltimov	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. I		Date of Birth (Month, Day, Year) 9. Birthplace (Stele or Foreign Country)
Director	213-03-9501 1□M 2√F 585 -86	Yrs. Months Days Hours Min.	lov. 30, 1914 Maryland
B	Usual Residence of Decedent 10a. State 10b. County 10c. City	r, Town or Location	10d. Inside City Limits
Many of she fied a	Md. Baltimore Ba	altimore	1 ☐ Yes 2 🖔 No
with the Ma t or 28a-f a be notified Director	10e. Street and Number 4403 FENOR ROAD	10f. Zip Code	10g. Citizen of What Country?
Mark Park	3232 Magnolia Avenue	21227	U.S.A.
020 ure after death with the Maryla st, or term 23a or 28a-f ahor caminer must be notified at by Funeral Director	11. Merital Status 1 □ Never Merried 2 □ Married 1 □ Never Merried 2 □ Married 3 □ Widowed 4 ☑ Divorced 12. Wes Decedent Ever in U; Armed Forces? 1 □ Yes 2 □ ₩o If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri □ Yes ¾□ No Specify: 	Specify:
	15. Decedent's Education	16a. Decedent's Usual Occupation	White 16b. Kind of Business/Industry
1 21215-0 ed within 72 ho ygiene. we than 'netur t, the Medical.	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)	
	8th 0	Waitress	Fountain Drug Store
Vlanc vid be fi Vental in riked off rife even	17. Father's Name (First, Middle, Last) ANDREW Archibald Johnson	Carrie	First, Middle, Maiden Sumame) Brandt
Maryland 42 should be file th and Mental Hy 7 is marked other traumatic event	19a. Informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Rural	
- 5994	Claire Gardner (Daughter)	3232 Magnolia Avenue Ba	altimore, Maryland 21227
Saltimore senti. Pages 1- lepartment of He important. If Item iny Injury or oth- inde.	20a. Method of Disposition 20b. P. 1 A Burial 2 Cremation 3 Removal from State	lece of Disposition (Name of emetery, cremetory or other place)	Date 20c. Location - City or Town, Stete
tim tent jury	4 Donation 5 Other (Specify)		3/00 Glen Burnie, Maryland
Balt Depart Import any inj ansa	Signature of Funeral Service Licensee Kevin E. E.	ckerycccully-Polyniak Fund 237 E. Patapsco Avenu	eral Home, P.A. ue Baltimore,Maryland 21225
	23a. Part1. Enter the disease, or complications that caused the death shock, or heart feilure. List only one cause on each line.	n. Do not enter the mode of dying, such as cardiac or	respiratory errest, Approximate Interval Between Onset and Deeth
Physician /Medical	Immediate Cause (Final	1	
Examiner	rossing in county	atic Lung Can	()
P = 5			
8760, sate be assected hystician and the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate	r es a consequence of):	
8760, sate be axe shrystcian are the buriel-t dical Ex	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
687 ifficate g physical policy graphysical policy g	resulting in death) Last	es a consequence of):	
death certific death certific attending pod for use as siclan/Mee	d		
O. B. se death the attended for yelcia	Part II. Other algorificant conditions contributing to death but not resu	ilting in the underlying cause given in Pert I.	23b. Did tobacco use contribute to the cause of death?
P. d by d by Setacy Setacy Setacy	Hypertensive Arterioscles	rotic Cardinvacalar Disea	1 Yes 2 No 3 Probably 4 Unknown
Records, ne law requires the law been signe uge 2 should be or	(\)		24a. Was an autopsy 24b. Were autopsy findings
lew require as been single bee			performed? available prior to competition of cause of death?
The law requirements has been single 2 should Completed			1 Yes 2 No 1 Yes 2 No
f Vital Repairs of the second	25. Wes case referred to medical examiner?	26. Place of Death	
나 아이 아이	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐		BAUGHTER'S RESIDENCE
After th funeral	27. Manner of Death 1 Netural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	28b. Time of Injury M 28c. Injury at Work?	d. Describe how injury occurred
Division or Attending later death. Director: After d in by the fune ertification			fl. Location (Street and Number or Rural Route Number,
Division of attending P re after death. al Director: After is in by the funers Certification:	4 Homicide building, etc. (Specify	"	City or Town, State)
DIVI: To the Heapital or Att Within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi		wedge, death occurred at the time, date and place, an ion end/or investigation, in my opinion, deeth occurred	
To the To the comp	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
	your Attendin Phys;	com D26203	12/30/99
2	30. Name and address of person who completed cause of death (Item	23a) (Type, Print) 4000 Annapolis R)	Baltimore mn 21227
State	31. Date filed (Month, Day, Year) 32. Registrer's Signel		المرادالمالا المراز كالمراد
Registrar	JAN 0 7 2000 Seneva	B. lood	

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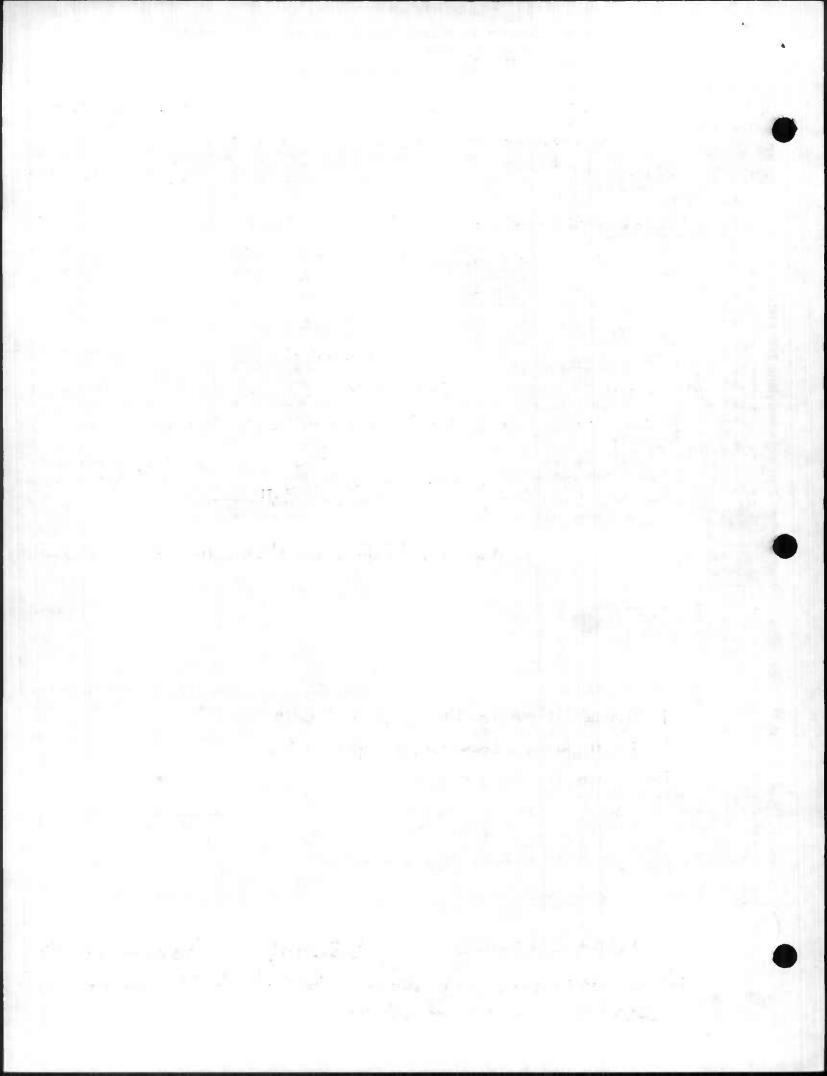
State of Maryland / Department of Health and Mental Hygiene
AMEND#22 PER F.H. & 26 PER MD. G779 1-7-2000 J.A. Certificate of Death

Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death Month **Physician** December 22 1242 William Johnson Sr. 1999 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Kent and Queen Anne's Hospital Chestertown 7. Age (In yrs. last birthday) If Under 1 Yaar 8. Data of Birth (Month, Day, Year) FEB. 04, 1926 9. Birthplace (Stata or Foreign Country)
VIRGINIA 5. Social Security Number 73 Yrs. **Funeral** Months Days Min 18 M 2 F 220-22-857 Director Usual Residence of Decadent the Meryland 10a State 10h County 10c. City, Town or Location 10d. fnslda City Limits 1 Yas 2.80 No HURCH Directo MARYLAND QUEEN 10e. Street and Number 10g. Citizen of What Country? Department of Health end Mentel Hygiene.
Department of Health end Mentel Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Mexical Exercises from the 30 PON SQUARE K

12. Was Decadent Ever in U.S.
Armed Forces? USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Datas: 1 Nevar Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: p 3 ☐ Widowed 4 ☐ Divorced BLACK Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 3 RD GRADE College (1-4or 5+) ABORER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) TOHNSON IURNE ALBERT 2 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 953 INNKEEPER DRIVE SEVERN, MD. 21144
Disposition (Nama of Data 206. Location - City or Town, State ELLA JOHNS DAUGHTER 20b. Place of Disposition (Nama of cemetery, crematory or othar place) 20a. Method of Disposition Burial 2 Cramation 3 Removal from State NATIONAL CEMETER 12-29-98 LAUREL
22. Name and Address of Facility BROWN JR. FEWNERS 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility BROWN JOSEPH FULLINGS AV 21. Signature of Funeral Service Dicensee any ir 40.2121 for the disease, or complications that caused tha death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate interval Between Onset and Death **Physician** arction Cardiac Arrest Immediate Cause (Final disease or condition resulting in death) /Medical 25 min Myocardia Examiner Examiner The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of) physicien e s the buriel-t Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical Dua to (or as a consequenca of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? DM Type II; Vascular Disease S/P Bilat BKA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? COPD; Alzheinors Domentia; Hr Pyloric Ulcer Perfacation. 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Procidence 64 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 DOA this After the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 5 Pending investigation To the Hospital or within 24 fours after death.
To the Funeral Director: After To the Funeral Director: After To the Funeral Hilled in by the fur or Attanding 1 Naturai 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of cartifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NELL StoppArs MO 100 Brown 32. Registrar's Sig 31. Dete filed (Month, Day, Year)
JAN 0 7 2000 State

Registrar



þ Be Completed Dage Certification: To

23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings 24a. Was an autopsy performed? evailable prior to completion of cause of death? Yas 2 - No Y Yes 2 No 25. Was casa rafarred to medical 26. Pleca of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 🎇 Rasidence 6 ☐ Othar (Specify) 1 Nas 2 No 27. Manner of Death 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 22 738 12-29-99 1 Yas 2 No SWSJOCK WAS Swor. invastigation 2 Accident 6 Could not be determined 3 D Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury: At homa, farm, streat, factory, offica building, etc. (Specify) 4 Homicida 6745-ATOWNS MOR DR. BSUTUPLED 1 Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as steted.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner steted. 29e. Certifier (Check only one) 29d. Data signad (Month, Day, Year) 29b. Signatura end title of certifie 29c. Licansa number

3. Time of Death

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Approximate Interval Batw

DECEMBER 30, 1999

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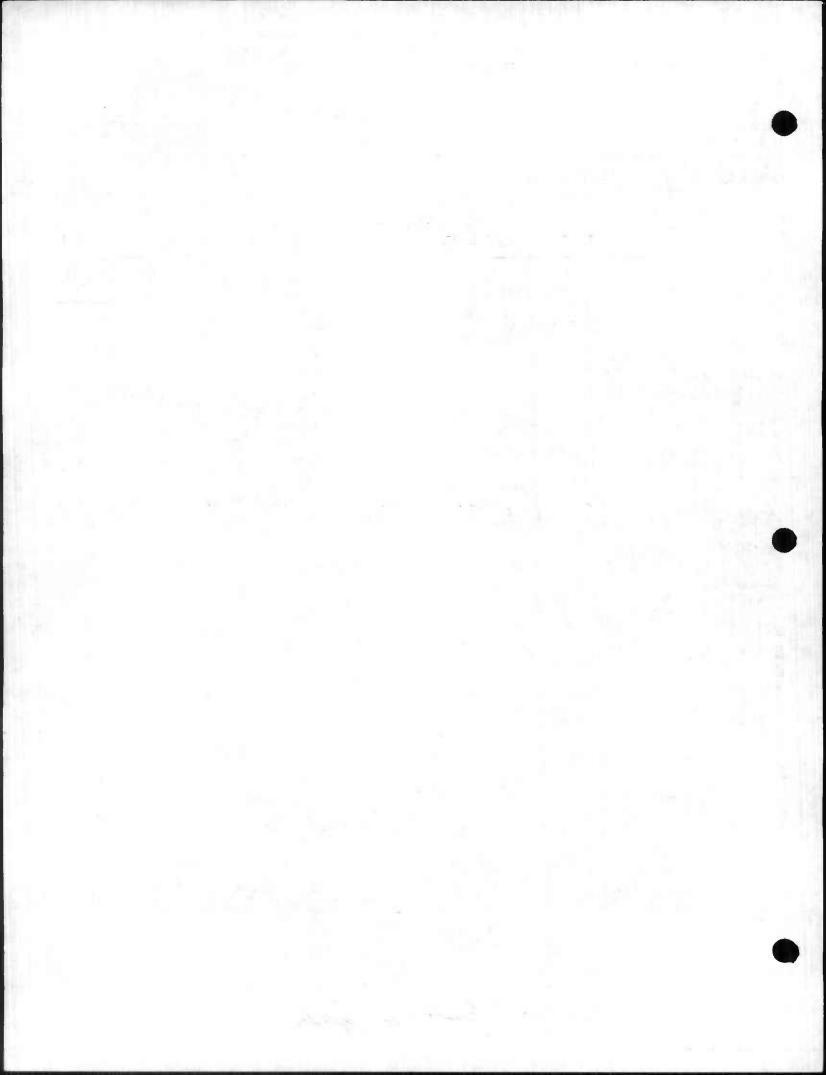
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162152 0 /// 111 Penn Street, Baltimore, Maryland 21201 32. Ragistras's Signatura

30. Nama and addrass of person who completed causa of death (Item 23e) (Type, Print)

OCME



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene AMEND#7 PER A.B. G779 1-7=2000 J.A. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 45 AL **Physician** /Medical 4e Facility Neme (If not institution, give street and no 4c. County of Dea Examiner 50N If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 1ay 2, 1923 Birthplace (State or Foreign Country) Age (In vrs. last birthday) Sex 10 M 2□ F **Funeral** 12 440 Months Days Hours Min 76 377 7F Yrs. May Ohio Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. fnside City Limits ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes ZX No Director MD Caroline Henderson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16539 Melville Rd 21640 USA death Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1♥1 Yes 2□No If Yes, Give Yeer or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14 Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiena.
Important if item 27 is marked other than "natural", or item
any injury or other traumatic event, the Medical Experimentation. Black, White, etc. 1 ☐ Never Married 2 Married 1 □ Yes 2 No Specify: White Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 0 Maintenence home improvements 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Stanley Kukla Salome Novak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ruth Kukla/wife 16539 Melville Rd Henderson, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Sprutere of Funeral Project Lightness Wade, Director 22. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, List only one cause on each line. Approximete interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner accident Examiner physician and the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest certificate be execu Box 68760. Physician/Medical Due to (or as a consequence of) 38 98 attanding Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? ed by the a Division of Vital Records, P.O. signed by t 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No λq 24b. Were eutopsy findings available prior to 24a. Was an autopsy performed? Completed peeu completion of cause of death? certificate has 1 Yes 20 No 25. Was case referred to medicel examiner? 26. Place of Death (Check only one) Be Hospitel: Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Menner of Deat 1 Neturel 2 Accident 28d. Describe how injury occurred innaral 28b. Time of 28a. Date of Injury (Month, Day Yeer) Certification: 28c. Injury at Work? After Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No death. To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted. Medical Cortifying Physician: 10 the best of my knowledge, deem occurred at the time, date and place, and due to the cause(s) and maintened as select.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. completely 29d. Date signed (Month, Day, Year) 29b. Signeture end title of cartifier 29c. License number 30. Name end address of person who co leted ceuse of death (Item 23a) (Type, Print) S 920 32 Registrar's Signature Mar Jan 85 31. Date filed (Month, 0 7 2000 State JAN U

Registrar

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Please Type or Print in Black Indeiible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Deeth 1. Decedent's Nama (First, Middla, Last) Day Month Year **Physician** EDWIN HARPER MCFEELY December 31,1999 10:55 PM /Medical 4a Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE-RUXTON NURSING CENTER TOWSON
If Under 24 Hrs.
Hours | Min. Baltimore County If Under 1 Year Birthplaca (Stata or Foraign Country) 8. Dats of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 F Director 215-12-9426 Mar 21, 1922 Maryland the Marylend 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f ahow 1 ☐ Yas 2 No Baltimore County Directo Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? re 23a or 7001 North Charles Street permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examine mass bings. 21204 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 1 Yas 2 No If Yes, Giva Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by Specify White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Insurance 2 yrs Salesman 18 Mothar's Name (First Middle Maiden Sumema) 17. Father's Name (First, Middle, Last) Be William James McFeelv Lucy Elizabeth Smith

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) (Sister-in-M. Jean Delaunev 20b. Place of Disposition (Name of Street) # Date Goste Location City of 15 M., State cometary, cramatory or other place) Law) 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 1/5/2000 Baltimore, Maryland 21. Signature of Funejal Server Usersen

Martin D. Latwson 22. Nama and Addrass of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore Maryland 21212 23a. Pert1. Entar the disease, or domplications that caused the death. Do not entar shock, or heart feitura. List only one cause on each line. Intervel Batween Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in death) Examiner Examine sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Box 68760. physician s the buria Physician/Medical Due to (or as a consequanca of): 980 23b. Did tobacco use contribute to the cause of death? Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4/2 Unknown signed t þ 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 1 Yas 2 No 1 Yes 2 No of Vitai or Attending Physicien: 25. Was casa refarred to medical examiner? 8 26. Place of Death (Check only one) To Other: 42 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28d. Describe how injury occurred Certification: 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After Division 5 Pending invastigation 1 Natural 1 Yas 2 No death. 2 ☐ Accident efter deatl Director: 6 Could not be 3 Suicide Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide filled In 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edicai completely (Check only one) To the To the To the F 29b. Signatura and titla of continu 29d. Date signed (Month, Day, Year) 30. Name and address of

State Registrar

31. Data filed (Month, Day, Year)

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23a) (Type, Print)

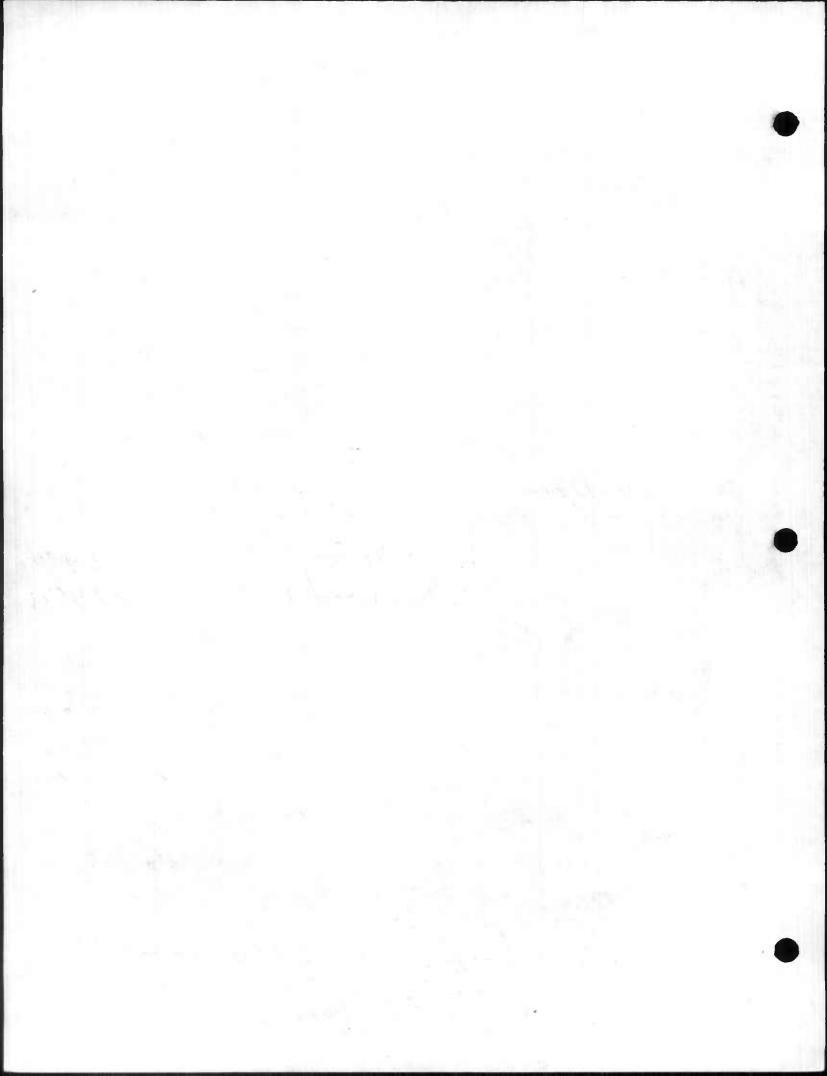
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this completed cause of death (Item MD.

2000

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32. Registrar's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month atherine Milke Dec 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Geriatric + Renat Center Bi Baltimore County NYHALL DALTIMORE if Undar 24 Hrs. Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1□ M 2☑ F Yrs. 218-46-4153 Aug. 20,1907 Maryland Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Baltimore County Baltimore Maryland 1 ☐ Yas 2€ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5003 King Avenue 21237 USA 11. Marital Status 12. Was Dacadant Evar in U.S. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - Amarican Indian, was Dacadant Everaged Forces? 1 ☐ Yas ※ No If Yes, Give Yaar or Dates: Black, Whita, atc. 1 Never Married 2 Married 1 Yes X No Specify: Specify: X ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Spacify only highest grada completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) N/A Housewife Housekeeping - Own Home 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margaret Frederick Conrad Reich 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland Arlene Roth (Daughter) 5003 King Avenue 20b. Place of Disposition (Name of Cardens, crematory or other place) Gardens of Faith Cem. 1-3-2000 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removel from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Fuperal Service Licensee 22. Name and Address of Fecility Lassahn Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPTICEMIA Immediate Cause (Final 12 Hours disease or condition resulting in death) as a consequence of): Y TRACT INFECTION Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobecco use contribute to the cause of death? ABETES MELLITUS, TYPE 2, UNCONTROLLED 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of ceuse of death? ATHEROSCLERATIC & HYPERTENSIVE CARDID-24a. Was an autopsy YASCULAR DISEASE 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homleide 1 Descriting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifie

attanding physician and I for use as the bunat-transit P.O. Box 68760, signed by Records. Division of Vital After this in by the funeral To the Hospital or Attending Pi within 24 hours after death. To the Funersi Director: After th completely filled in by the funera

Physician

/Medical

Director

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Examiner

Funeral

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event. In Minimals.

Physician

/Medical

Examiner

be executed

Iner

Physician/Medical

Be

2

Certification:

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 0 7 2000

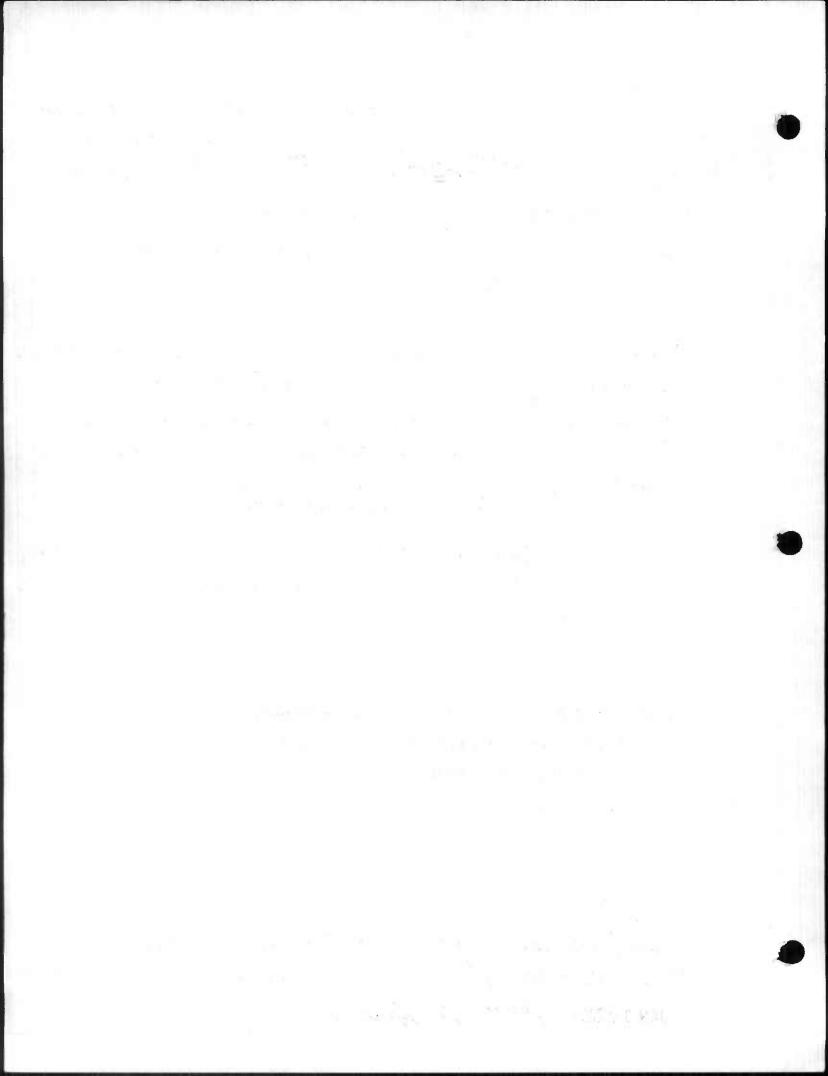
Baltimore, Maryland 21215-0020

State Registrar HILADEL

29cy License number V/5022

29d. Date signed (Month, Day, Year)

BALTIMORE, MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Neme (First, Middle, Last) DECEMBER 31, 1999 9:15 PM John Pugevicius 4c. County of Death Baltimore 4a Facility Nama (II not institution, give street and number) Saint Joseph Medical 4b. City, Town, or Location of Death Center Towson Hours Min. 8. Data of Birth (Month, Day, Year) 919 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex Birthplaca (Stata or Foreign Country) Days 1 M 2 F Months 220-22-8398 30 Yrs. Maryland Usual Rasidance of Decedant 10c. City, Town or Location 10a. Stata 10b. County 10d. Inside City Limits Maryland Baltimore 1 ■ Yas 2 No 10e. Street and Number 10l. Zip Code 10g. Citizen of What Country? 1327 Kitmore Road 21239 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, 11. Maritel Status 12. Was Decedent Evar in U,S. Armed Forces? Black, Whita, atc. 1 Yas 2 No If Yes, Giva Year or Dates: 1 Never Merried 2 ☐ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+) Non-Profit Assembly Worker 17. Father's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumama) Kazimeras Pugewich Veronica Dauderiute 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State-Zip Code) 120 N. Front St. Baltimore Maryland 21202 19a. Informant's Neme/Ralationship (Type, Print) Rev. Casimir Pugevicius/Brother 20b. Place of Disposition (Nama of camatery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cramation 3 ☐ Removal from Stata 1/6/2000 Baltimore, Maryland Most Holy Redeemer 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility David J. Weber Funeral Homes, P.A. 21. Signatura of Funarel Sarvice Licenti 5311 Edmondson Ave, Baltimore Maryland 21229 Tuves 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death PNEUMONIA 5 DAYS Immedieta Causa (Final diseasa or condition rasulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? 2 No 1 Tas 1 🗆 Yas 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidenca 8 Other (Specify)

Physician Aviedical Examiner

be exacuted

Box 68760.

P.O.

Records,

Division of Vital or Attending Physician:

The law requires

certificata has

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Nems 23s

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permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "naturary injury or other traumatic avare secure."

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

traumatic avant, the Medical Examiner must be notified at

Examiner physician and s the burial-transit attending p detached signed by t been si page 2

Physician/Medical þ Completed Be Certification: To

this funeral After s after dea. To the Hospital or within 24 hours aft To the Funeral Di completely filled in Medical

State Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE ISCHEMIC HEART DISEASE 25. Was casa rafarred to medical examiner? Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Netural 5 Pending 1 Tyes 2 No Invastigation 2 Accidant 3 Suicide 6 Could not be 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 4 Homicide 29a. Certifier (Check only one)

29b. Signeture end title of certifian

29c. License number 030263

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

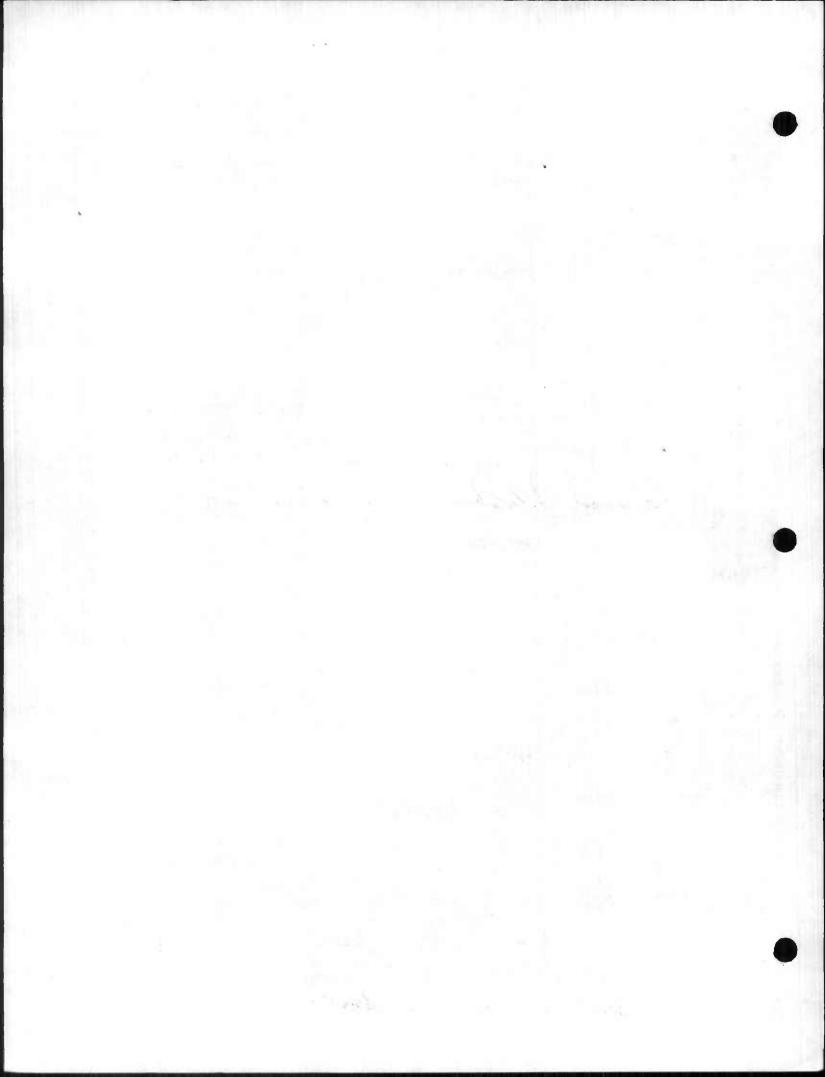
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the tima, data and placa, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year) 1-00

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print)
FRANCIS KHOD M. D. 7601 OSLER DRIVE TOWSON, MD. 21204

31. Dete filed (Month, Day) (77) 2000

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Dev Month Year **Physician** Edwin Leroy Reichhardt 1999 December 30 5:40 RM /Medical 4e Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SQUARE BAITIMORE FRANKlin Rosedale If Under 24 Hrs. 8. D ItospilA1 Center 6. Sex 1 M 2 □ F 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys Months Hours 215-07-1891 Director 88 Aug. 30, 1911 Philadelphia, PA. Usual Residence of Decedent the Maryland 10a Stele 10b. County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show Show 1 ☐ Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? reast bar 8620 Kelso Drive Apt.C-103 21221 Funeral U.S.A. Nome: 14. Race - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Bleck, White, etc. traumatic avent, the Medical Examiner 72 hours after Yes 2 No 1 Never Merried 2 Merried Specify: White 21215-0020 ò 1 Yes 2 No Specify py 3 Nidowed 4 Divorced Yeer or Dates Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 yrs. College (1-4or 5+) Hygiena. n/a Marketer Barton, Duer, Koch Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be nent of Heelth and Mental Oscar Reichhardt Alice McClelland 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Heelth am 27 la M's Ruth Verzier (Daughter) P.O.Box 106 Upper Falls, MD. 21156 Baltimore, or othe 20e. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Dete 1 X Buriel 2 Cremetion 3 Removel from State Important: If any injury o poce. Department 4 ☐ Donetion 5 ☐ Other (Specify) Moreland Memorial Cem. 1/4/2000 Baltimore, Maryland 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility E.F.Lassahn Funeral Home 23a. Pert1. Enter the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. 11750 Belair Road Kingsville, MD. 21087 Approximate Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Final · RupTuned AORTIC Angurysm diseese or condition resulting In death) Abdominal Examiner Due to (or as a consequence of): Examiner The law requires that the deeth certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760, Physician/Medical the Due to (or as e consequence of) 980 signed by the a Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes en autopsy parlormed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Attending Physician: 25. Was case reterred to medical 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To this 27. Magner of Death 28e. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Neturel 5 Pending 24 hours after death. Funeral Diractor: Aft petaly filled in by the ful 1 ☐ Yes 2 ☐ No 2 Accident investigetion 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide ò 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29e. Certifier edical (Check only one)

To the State Registrar

JAN 07

296. Signature and title of certifier

29d. Date signed (Month, Day, Year) December

ame and address of parson who completed cause of deeth (Item 23a) (Type, Print)

James Nicholson 9000 FRANKlin Square DR. BAITIMORE MARYLAND 21237

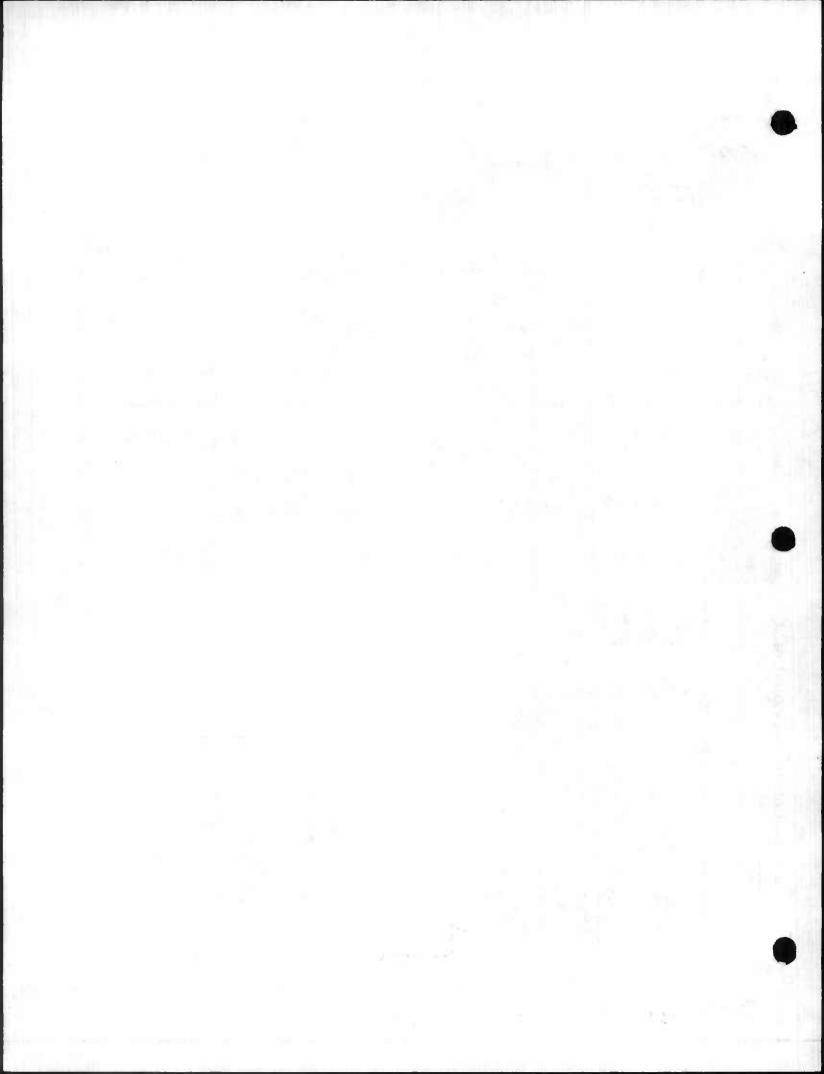
31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture

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29c. License number

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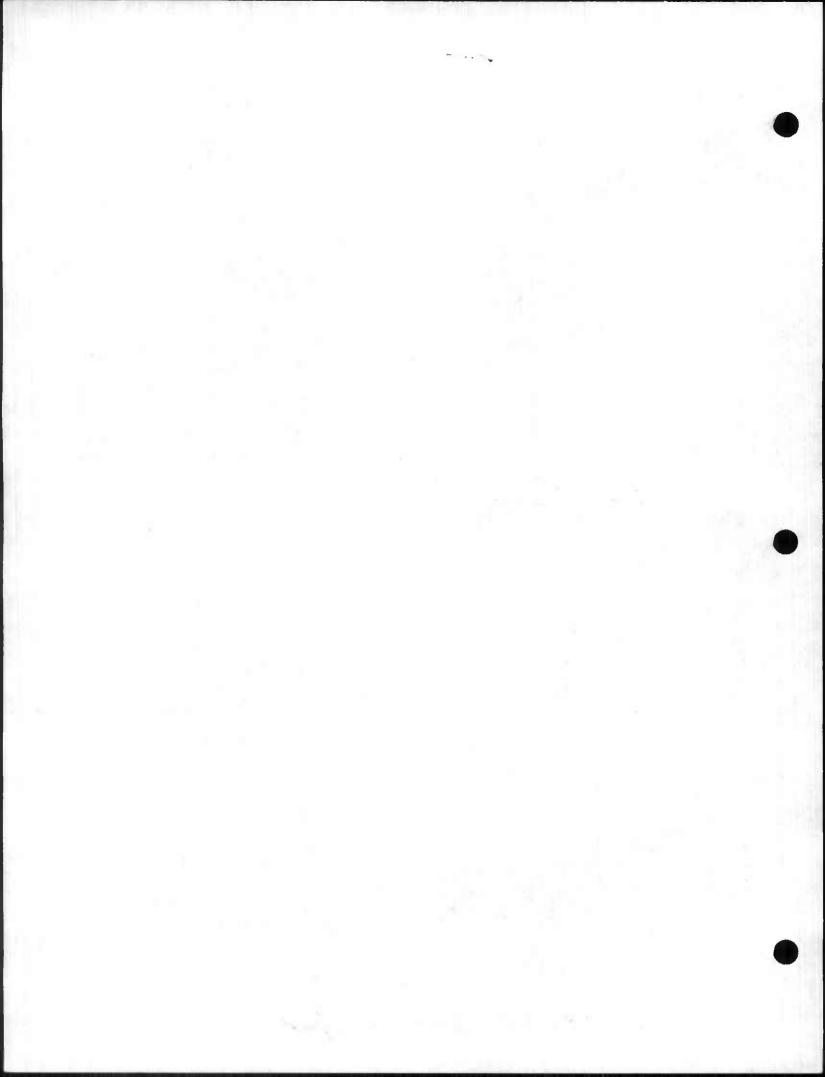
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State of Maryland / Department of Health and Mental Hygiene

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			Ce	rtificate of	Death		Reg. No.		1154		
Physician	1. Decedent'a Name (First, Middle, La	•				2. Date of D	Dey	Yeer	3. Tima of Death		
/Medical		Rossman				Decem	1 /	1999	8:30 a.m.		
Examiner	4a Facility Name (If not institution, given Genesis Elderca	are Hamilton				imore		N/A			
Funeral Director	5. Social Security Number 6. S 217–16–6849	Sex 7. Age (In)	76 Yrs.	Months Days		Min. Sept.	20, 1923	9. Birthpl Count Mai	ace (Stete or Foreign try) Cyland		
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of the Market of the Market of the Cool of	10e. Street and Number 4409 Furley Ave	enue		10f. Zip Code	1206		10g. Citizen of V	what Count			
ter dea	11. Meritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub- 1 ☐ Yes 2 No		n? (Specify Yes or N Puerto Rican, etc.)	o- 14. Raci Blac Specify	a - America k, White, e			
Maryland AIAID-UOAU d 2 should be filed within 72 hours at h and Mental Hygiens at the and Mental Hygiens The merical other than "natural", or traumatic event, the Medical Exam To Be Completed by I	15. Decedent's E (Specify only highest gr.	ducation ade completed) Cotlege (1-4or 5+)	(Give	dent's Usuel Occup kind of work done DO NOT use retire	during most or	f working	16b. Kind of Bu	usiness/Ind	lustry		
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y ican ouid be Mental mrked o milc ev		ster				nie Dora					
	Janice Krauss Kar	ne / Daughter	440	9 Furley			ore, Mary	land	21206		
dellimore, emit. Pages 1 at apartment of Hea reportant: If Nem 3 ny Injury or other BISB.	20a. Method of Disposition 1 🗓 Burial 2 🗆 Cremation 3 🖺 4 🗆 Donation 5 🗀 Other (Speci.	Removel from State	cametery, cre	osition (Name of metory or other ple dge Mem.		12/31/99	20c. Location · Dorse		wn, State aryland		
Demit. Departimports any inji	21. Signeture of Funeral Service Lice	Michael E. Ca	anapp 2	2. Neme and Addre Leonard		k, Inc.	5305 Baltimo		ord Road D 21214		
Physician /Medical Examiner	23a. Pert1. Enter the disease, or comshock, or heart feilure. List only immediate Ceuse (Final disease or condition	one cause on each line.		ter the mode of dyi		ardiac or respiratory	errest,	1 1 1	Approximate Intervel Between Onset and Death 9 Years		
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2 2 3 4	24a. Was an autop performed?							ava	ere autopsy lindings allable prior to mpletion of cause death?		
VITAI REC iclan: The law certificate has rector, page 2	25. Was casa referred to medical				26 Place o	1 Death (Check only	Yes 2 No	1 [Yes 2□ No		
Or VITA Physician: this certific ral director,	examiner? 1 ☐ Yes 2 No	Hospitet: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Oth		ing Homa 5 □ Res		er (Specif)	y)		
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Hospi 24 hou Funer Hely fill		nysicien: To the best of my miner: On the basis of exam end menner stated.									
To the To the comple	29b. Signature and title of certifier	are MO		29c. Licens	6619		29d. Date signe	9, 1	Day, Year) 999		
MIN	30. Name and address of person who	ARES 60	40 HA	Print)	RD. 1	BALTIMOR	E, MO	. 212	14		
State Registrar	31. Date filed (Month, Dey, Year)	32. Registrar's Si 0 7 2000	gnature	G	loo. V	4					

DHMH 16 Rsv 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q AMEND#20a PER F.H. G779 1-7-2000 J.A. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** December 30 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If hot institution, give street end number) Examiner ARylana 5 10 mor If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth Month, Dey, Year lest birthdey) 9 Birthplece (State or Foreign 5. Sociel Security Number **Funeral** MM 20 F Months Deys Hours Min 218-10-3645 Usuel Residence of Decedent Director 24.1716 Dou arolino the Maryland 10a. State 10b. County City, Town or Location 10d. Inside City Limits r 28a-f ahow 1 Yes 2 No Maryland Director mo1 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number with 7 is merked other than "natural", or items 23a or traumstic event, the Medical Examiner must be a Funeral Pages 1 and 2 should be filed within 72 hours efter death nant of Hashin and Mantal Hygiene. 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 DNo if Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian 11. Meritel Status Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-d020 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surgame) Be enc 10 19a. Informent's Name/Reightionship (Type, Print) daughter 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Health Item 27 OX Piece of Disposition (Neme of cemetery, cremetery or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition Department of Important: If it any Injury or o 1 Suriel 2 Dicremetion 3 Removel from Stete remator 2000 4 □ Donetion 5 □ Other (Specify) Greenmoun 21. Signature of Funerei Service Ligensee 22. Name end Address of Fecility Joseph 2222 V a 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shot, or heart failure. List only one cause on each line. 2/2/6 Ito. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Finel disease or condition resulting in death) Examiner Examiner INSUSTICIENCY g physician and as the buriel-transit requires that the death certificate be executed Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury Division of Vital Records, P.O. Box 68760, Sport tory Failur
Due to (or es e consequence of): Physician/Medicai that initiated events resulting in death) Last Phalopathy esn 23b. Did tobacco usa contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert II. signed by t d be detect 3 Probably 4 Unknown 1 | Yes 2 | No by 24b. Were eutopsy findings evaileble prior to completion of ceuse of death? should 24a. Was en eutopsy Completed page 2 has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Attending Physician: director. 25. Wes cese referred to medicel examiner? 26. Plece of Deeth (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Deeth 28b. Time of 28c. injury et Work? Certification: After 1 Netural 5 Pending investigation 2 No 1 Yes deeth. 2 Accident 24 hours after deel Funeral Director: 6 Could not be determined Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 Homicide 0 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end mannar as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) end menner stated. 29a. Certifie To the Hosp within 24 hor To the Fune completely fi (Check only one)

State Registrar 29b. Signeture end title of certifier

AKASH

31. Date filed (Month Day

7 2000

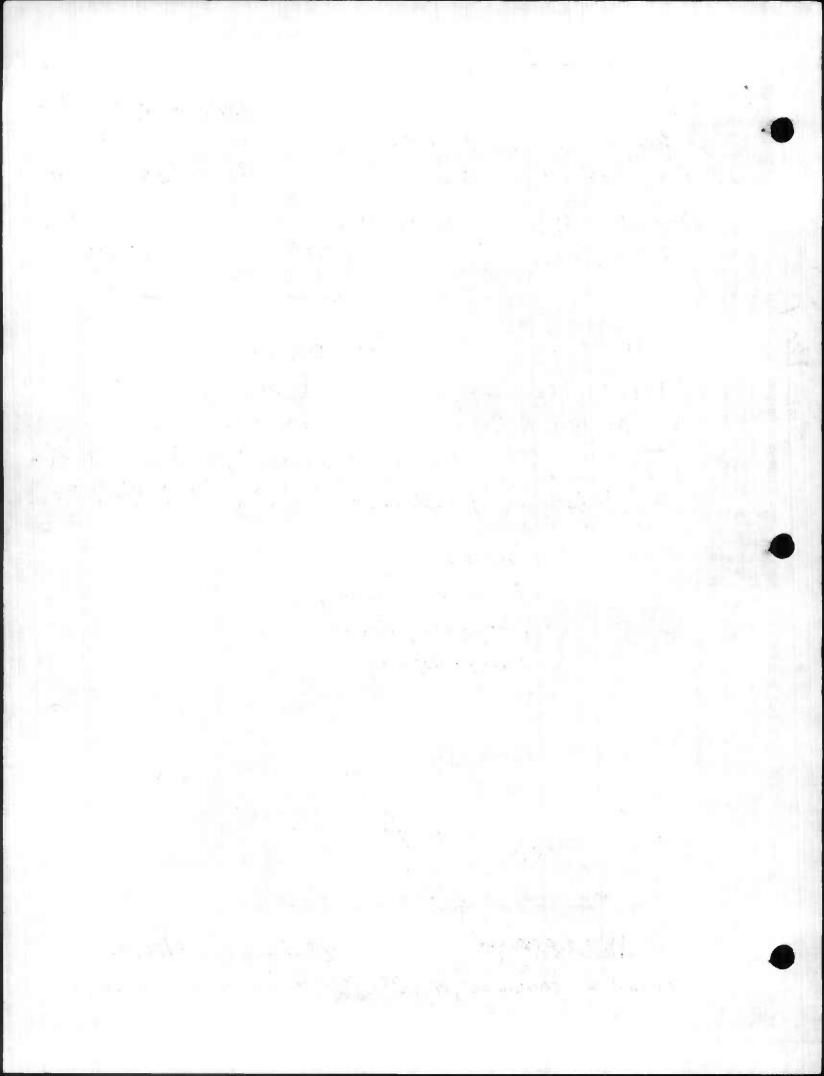
TAGGARSE 2. Registrate Signatura

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print) BRYland GENERAL HOSpITAL

29d. Date signed (Month, Dey, Year)

12/31

29c. License number



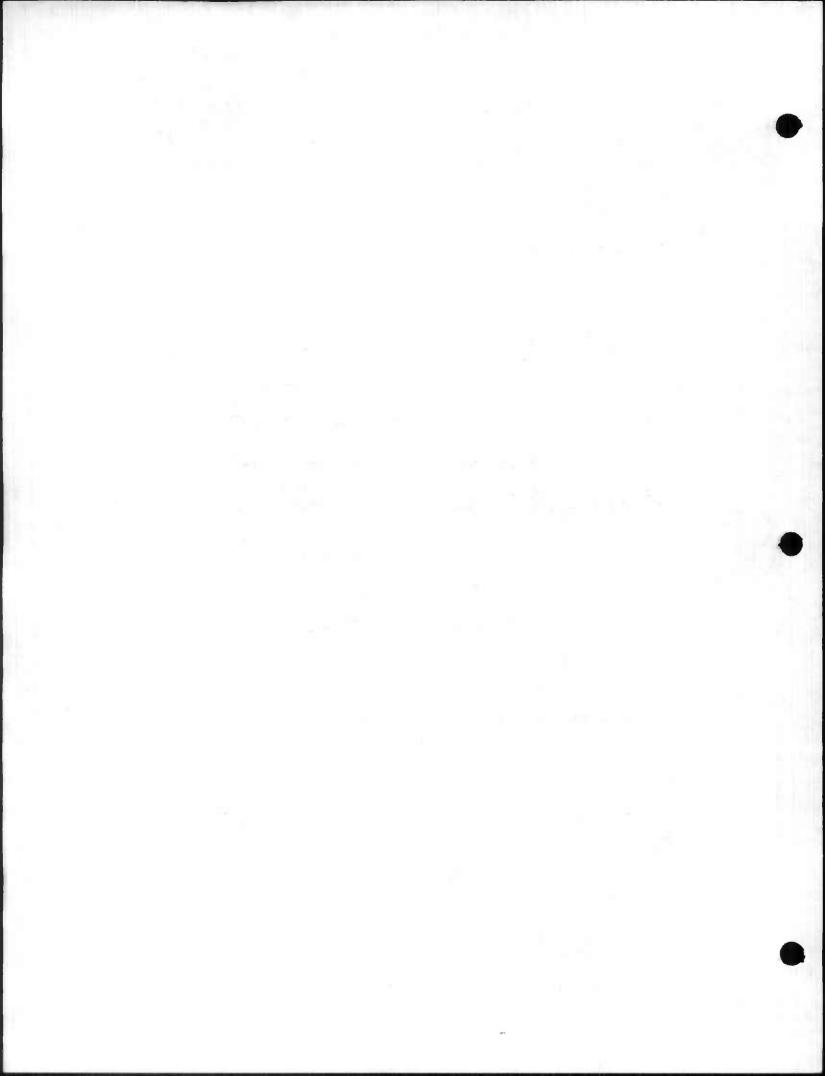
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Deeth **Physician** 31^{Pay} - 1999 1:30 PM Sherpinski John /Medical 4a. Facility Nama (If not institution, give streat and number) 4b. City, Town, or Location of Daeth 4c. County of Deeth Examiner Baltimore 7232 Gough Street if Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) MD **Funeral** 1**∑**M 2□ F Days 220-36-9145 58 Yrs. Director Usual Rasidanca of Dacedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits MD N/A 1 □Xas 2 □ No Baltimore Director 10e. Streat end Number 10f. Zip Coda 10g. Citizen of Whet Country? 21224 7232 Gough Street USA Funeral 12. Wes Decedant Evar in U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11. Maritei Status Black. Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No If Yas, Giva X Yaar or Datas: 1 ☐ Yas 2 ☐ No by Specify: White 3 ☐ Widowed ♣☐ Divorcad 15. Decedant's Education (Spacify only highast grada completed) 16e. Decedent's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) Merchant Marine Seaman 17. Fethar's Nama (First, Middle, Last) 18. Mothar's Name (First, Middla, Maidan Sumama) Be Unknown Unknown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Mr. John Brooke 1719 Gough Street, Balto., MD 21224 20b. Placa of Disposition (Nama of cemetary, cramatory or other placa) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 NOther (Specify) Burial @ Sea Atlantic Ocean 1-21-00 21. Signatura of Funeral Sarvice Licensas 22. Nama and Addrass of Facility Kaczorowski F.H. 1201 Dundalk Ave., Balto., MD 21222 23a. Pert1. Enter the disaasa, or conc. Cations that causad the death. Do not antar the mode of dying, such es cardiac or respiratory arrest, shock, or read failure. List only one causa on each line. Approximata Intarval Batween Onsat and Deeth **Physician** Immadiata Causa (Final disaasa or condition resulting in daath) /Medical Congestive boart Failne Examiner Examiner Dua to (or as a consequence of or Attending Physician: The law requires that the death certificate be associted after death.

Director: After this certificate has been signed by the attending physician and the burial-transit Sequentially list conditions, if any, laading to Immadiata causa. Enter Undarfying Ceusa (Disaasa or Injury that initiated avants rasulting in daath) Last Box 68760, Bul namery Hyperters.
Dua to (or as e consequence of): Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of Vital Records, P.O. 23b. Did tobacco usa contribute to the cause of death? utes mellites, Climin of Liver 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of causa of death? Completed 24e. Wes an autopsy performad? 1 Yes 2 No 1 ☐ Yas 2 No director. Be 25. Was casa rafarred to medical exeminar? 26. Place of Deeth (Check only ona) Other: 4□ Nursing Homa 5 Residence 6 □ Other (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Mennar of Daath 28a. Data of injury (Month, Day Year) 28d. Dascriba how Injury occurred 28b. Tima of 28c. injury at Work? 5 Panding invastigation 1 Natural 2 Accidant 1 Yas 2 No 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, straat, factory, offica building, atc. (Spacify) filled in by 4 Homloida Hospital 24 hours a 24 hours a Text Cartifying Physician: To the bast of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Cartifiar Medical completely (Check only one) To the Vithin 2 29d. Data signed (Month, Day, Year) 30. Nama and address of person who completed ceusa of death (Item 23a) (Type, Print) BALTO, mel 21224 3508 ROBERT LIBERTU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 0 7 2000 Registrar

DHMH 16 Rev 6/95

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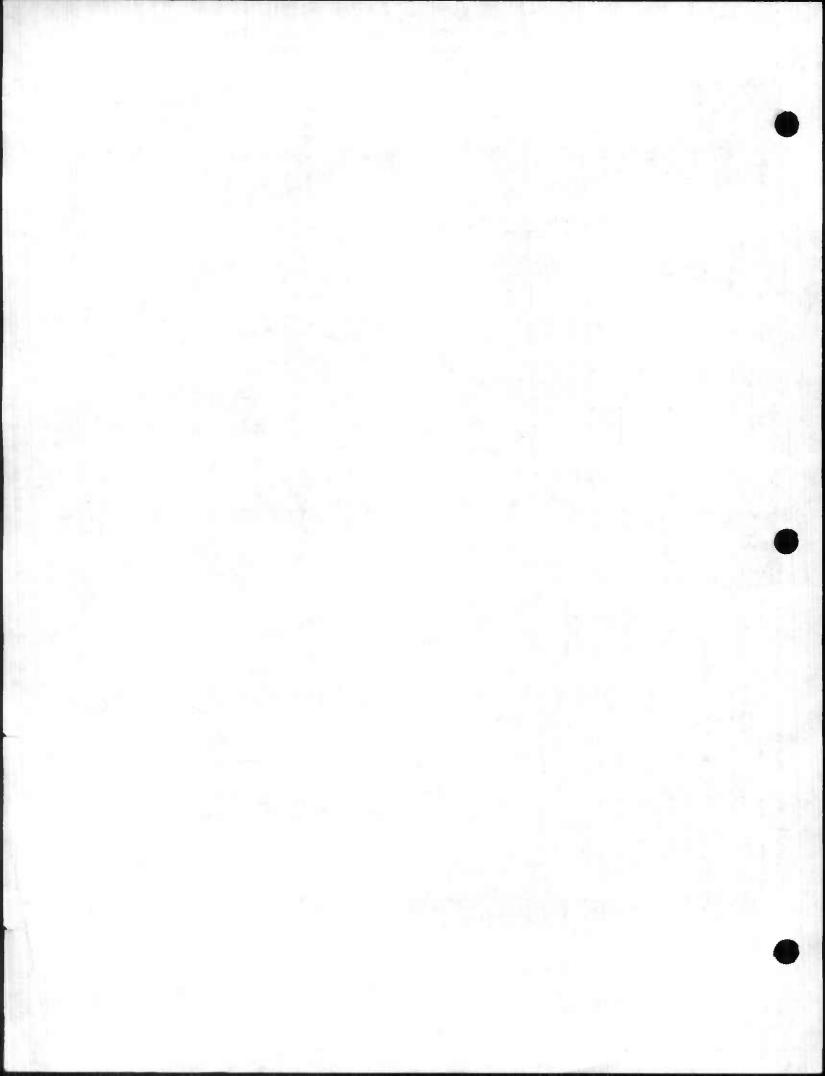


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State of Maryland / Department of Health and Mental Hygiene

#23 PART I 27 284 F RED MEO 0770 1 10 200 1 WIXIE

ician	1. Decedant's Nama (First, Middla, Las.					2. Data of De Month	Day	Year 1999	3. Time of Death 5:27 PM	
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al or	215 · 74 · 0825 10	JM 20 F 36		Months Days	Hours Mi	08 30	y. Year))·63	Count	m _D	
	10a. Stafe 10b. County	10c.	City, Town or Loca	tion				10	od. Inside City Limits	
to	mo N/	Ba Ba	ALTIMORI	E					1 ✓ Yas 2 ☐ No	
iner must be notified. Funeral Director	10e. Street and Number			10f. Zip Coda			10g. Citizan of \	What Count	try?	
	1333 GLENWOOD	AVENUE		212	139		l	ISA		
	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U,S. 13. Wa	as Decedent of H	ispanic Origin? an, Mexican, Pu	Specify Yas or No rto Rican, atc.))- 14. Rad Blad	e - Amarica ck, Whita, a		
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Be C	17. Fathar'a Nama (First, Middle, Last)				18. Mothar's N	ama (First, Middle	, Maidan Suman	na)	4-04-0	
O B	J. C. SPEARMAN				DOROTH	GRAHA	m			
	19a. Informant's Name/Ralationship (7)	ype, Print)	19b. Malling	Addrass (Street	and Number or	Pural Routa Numb		Stata, Zip	Coda)	
	YVETTE HARRIS	SISTER	1333 G	LENWOO	DAVE.	BALTO. 1	mo. 21:	239		
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	21. Signature of Funaral Sarvice Licens	saa n		Nama and Addre		250				
	1) auch (M	515	BAUD.	MATL P	IKE BAI	vo. mo	. 21:	229	
	23a. Part1. Enfer the disease, or comp ahock, or haart failura. List only of	lications that caused the de	aath. Do nof enfer	the mode of dyir	ng, such as card	ac or raspiratory a	irrest,	1	Approximate Interval Batwaan Onsat and Death	
		COCATNI	Z AND N	м D СОТТ (TNTOS	T C A T T OI	AT.		Onsat and Death	
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Examiner		b								
Exa	Sequentially list conditions, if any, leading to immadiate ceuse. Entar Undarlying Causa (Diseasa or injury c.									
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Medi	rasulting In daath) Last									
an		d						1		
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Med	one)	end manner stated.					29d. Date signs			
-	29b. Signatura and titla of certifier	, 1/ 00.	un	29c. Licans	C.M.E.		DECEMBE			
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	0000000	0 / 10	Control of the Contro							
	30. Nama and address of person who c		tem 23a) (Type, Pr 111 Penn		Dal+i-	oro Ma-	wland 21	201		



State Registrar

2000 FEB 0 1

31. Deta filed (Month, Dey, Year)

JACK MITITUS m.D 32. Registrer's Signal fre

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

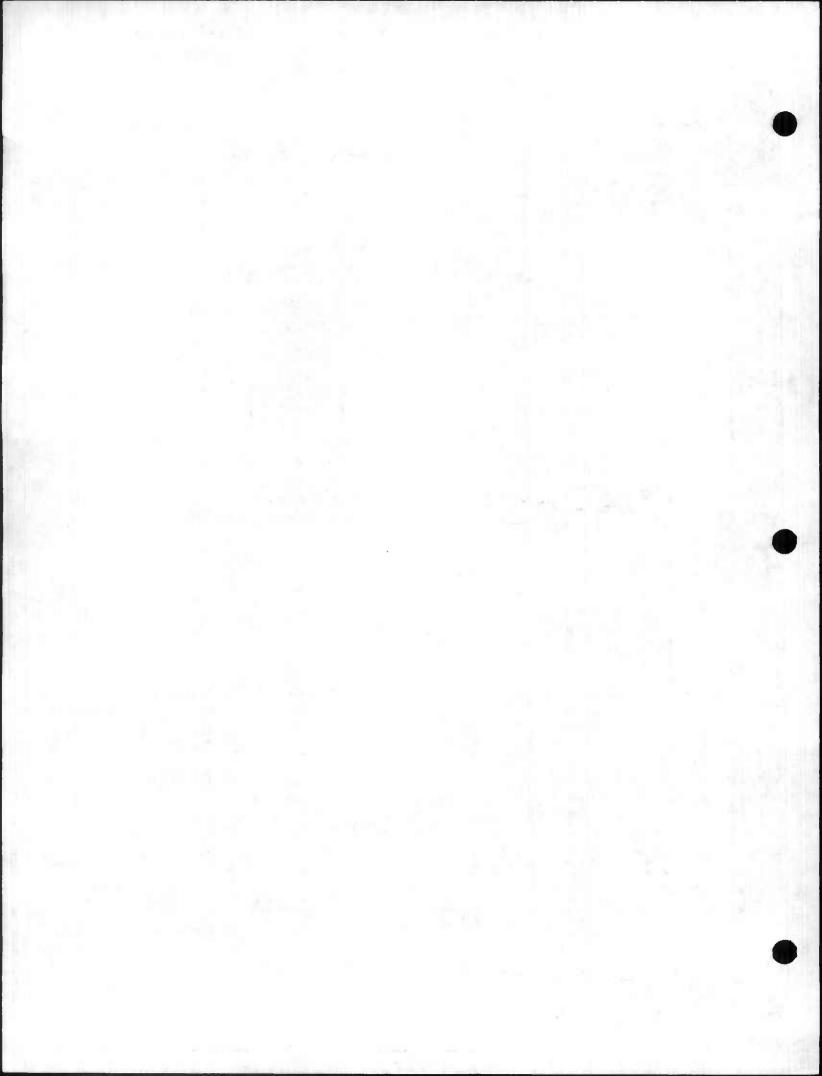
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State of Maryland / Department of Health and Mental Hygiene 994 93

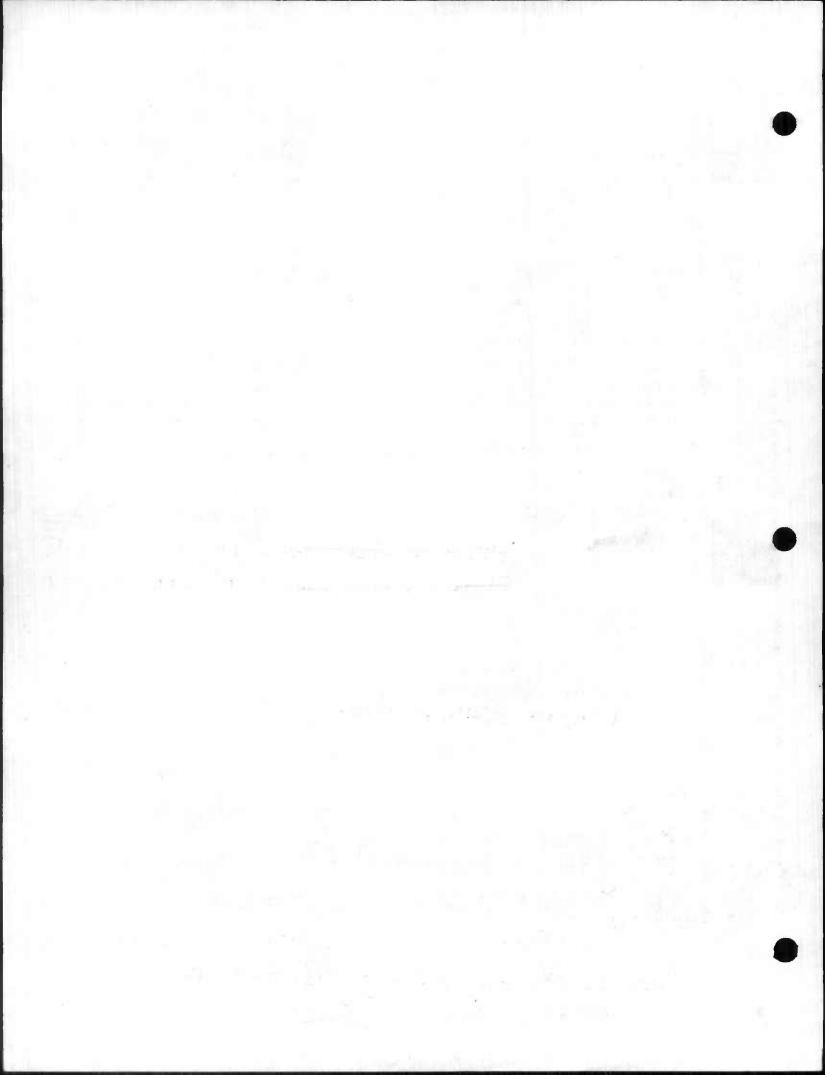
Lawson W	alters			Certifica	te of	Death		P	Reg. No.			
	1. Decedent's Name (First, Middl							2. Date of Dea		Vans	3. Time o	d Death
Physician	Lawson 0.	Walter	S					Month Decembe	er 27	Year 1999	08:4	47 AM.
/Medical Examiner	4a Facility Name (If not institution	n, give street and numb	er)		4	4b. City, To	wn, or Lo	ocation of Death	4c. County	of Death		
	Rear of	1300 Edmor	ndson Aver	nue		BAJ	Ltimo	ore		N/A		
Funeral	5. Social Security Number		Age (In yrs. last birth	hday) If Under	Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Dey	Year)	9. Birthpl	lace (State of	o <i>r Foreig</i> n
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ter de	11. Marital Status 1 ☑ Never Married 2 ☐ Marri	Armed Force	s?	If Yes, sp	ecify Cuba	an, Mexican	, Puerto	ecify Yes or No- Rican, etc.)	Blac	k, White, 6		
d within 72 hours aft plane. It than "natural", or the Medical Exert. Completed by F	3 Widowed 4 Divorced	If Yes Give		1 ☐ Yes	2/200	Specify:			Specify	: B	Black	
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	Thomas Walte	ers				M	erl	e Alki	ns			
w = 3	19a. Informant's Name/Relations	hip (Type, Print)	19b.	Meiling Addres	s (Street	and Numbe	er or Rura	al Route Numbe	r, City or Town,	Stete, Zip	Code)	
	Merl Walters	s / Mothe	r 3	05 C1	arks	on A	ven	ue, Br	ooklyn	NY	112	26
5 2 2 0	20a. Method of Disposition		cometen	Disposition (Na	other place	ce)	1	Date	20c. Location -	City or To	wn, State	
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고통환경	21. Signature of Funeral Servica	Licensee Victor I	P. Doda, Jr.	22. Name a	nd Addre	ss of Facilit	y	Funeral	Homo	Tna		
permit. Peges 1 at Department of Hee Important: If tem any injury or other ence.	1 DCE	TAX	.>	1501	East.	Fort	Aver	nue, Bal	timore	MD :	21230	
	23a. Part1. Enter the disease, or	complications the cau	sed the death. Do n	ot enter the mo	de of dyir	ng, such as	cardiac	or respiratory ar	rest,		Approxima	ite
Physician	shock, or heart failure. List	only one dause on eac	n line.	1		1		1	. A	1	Onset and	
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certificate harrector, page	25. Was case referred to medica					26. Place	of Deet	h (Check only o	ne)	1		
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g Physical Person	27. Manner of Death		njury FOUNG b. T	ime of Faund	28c. fnjur			28d. Describe h			oject	
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or Attendate desti Director: 3 in by the	3 ☐ Suicide 6 ☐ Could determ	ined 200. Place of	Injury - At home, far etc. (Specify)	m, street, facto	ry, office	Fiel	d	28f. Location (S City or Tow	Street and Numb		/ Route Nu	mber,
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To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral Medical Certification:	29e. Certifier 1 Certifyin	o Physician: To the be	st of my knowledge	death occurre	d at the tir	me date an	d place,	and due to the	ceuse(s) end ma	anner as si	tated	(a)
n 24 n 24 n 24 n Fu	(Check only one) 22 Medical	Examiner: On the basi and manner	s of examination and stated.	vor investigatio	n, in my o	ppinion, dea	ith occur	red at the time, o	dete end place,	and due to	the cause	(\$)
Withlit To the comp	29b. Signature and title of certifie	r .		2	c. Licens	se number			29d. Date signe	d (Month,	Day, Year)	
	D. Hoi	tone. 1	M.D		0.	C.M.E			Dece	mber	28, 1	999
11	30. Name and address of person	who completed cause	of death (Item 23a) (Type, Print)	٠.				DCCG	- LUCL	20, 1	,,,
\sim	Lose	ph Pest	taner	111 Pe	nn S	treet	, Ba	ltimore	, Marvl	and 2	21201	
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Registrar	JAN 07	2000	never /	y Sp	rack	2						



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123a P	State of Maryland / Department of Health and ER MD. G779 1-7-2000 J.A. Certificate of Death		giene Reg. No. 9	9 41932
sician ledical	Decedent's Neme (First, Middle, Last) JENNIE I WADSWORTH	2. Date of De Month DEC 2		3. Time of Death 12:12pt
eral	4a Facility Name (If not institution, give street and number) 3 debkay Court 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) 1 \square M 280 F 81 Yrs. 4b. City, Town, or ESSEX For Months Days Hours Min.	8. Date of Birt	Ва	of Death 1 timore 9. Birthpleca (State or Foreign Country) PA
	Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Limits
ral Director	Md Baltimore Essex			1 ☐ Yes 200 No
Director	10e. Street and Number 10f. Zip Code		10g. Citizen of V	
Funeral	3 Debkay Court 21221 11. Maritel Stetus 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	specify Yes or No		USA e - American Indien,
•	Armed Forces? 1 Never Married 2 Merried 1 Yes 2 No 1 No 2	to Rican, etc.)	Specify	k, White, etc. White
-	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	rking	16b. Kind of Bu	siness/Industry
	Elementary/Secondery (0-12) College (1-4or 5+) Factory Worker		Cur	p Company
		me (First, Middle,		
	19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Re			
	Donald Wadsworth / son 3905 East Joppa Roa 20a. Method of Disposition 20b. Place of Disposition (Name of	Date Date		Maryland 21236 City or Town, State
	1 K Buriel 2 Cremation 3 Remove from State cemetery, crematory or other place)	/28/99		imore Md.
	21. Signature of Funerel Service Licansee 22. Name and Address of Facility			
	23a. Pert 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac shock, or heart leiture. List entry one cause on each line.	eral Hom	ne of Es	sex
Physician/Medical Examiner	resulting in death) Due to (or as a consequence of):	UREMIA HRONIC REN	IAL FAILUR	E Zyrari
an/M	d			
	Part II. Other algoriticans conditions contributing to deeth but not resulting in the underlying cause given in Part I.		tobacco use cor Yes 2 No	atributa to the causa of death
		24a. Wes	an autopsy med?	24b. Were eutopsy findings available prior to completion of cause of deeth?
		101	Yes 2 No	1 ☐ Yes 2 ☐ No
2	axaminer? Hospital:	eth (Check only o		
0 :-	27. Manner of Death 28a. Dete of Injury 28b. Time of 28c. Injury at		dence 6 Other	
Certification:	1 Neturel 5 Pending (Month, Day Year) Injury Work? 1 Yes 2 No	28f. Location (S		er or Rural Route Number,
Medical Cer	29a. Certifier (Check only Certifying Physician To the best of my knowledge, death occurred at the time, date and place Check only Check only	a, and due to the	cause(s) end me	nner as stated. and due to the ceuse(s)
Med	29b. Signeture and the of certifier 29c. License number 197		29d. Dale signed	Month, Day, Year)
	30. Name end address of person who completed cause of death (Item 23a) (Type, Print)	nere, T	70 21	224
ate	31. Dete liled (Month, Day, Year) 32. Registrar's Signature			
e Ir	DEC 2 9 1999 1 remove 19 Jan 1)			

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month December 15, 1999 **Physician** 10:45AM FRIEDA **AARON** /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT. 24, 1908 9. Birthplace (Stete or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2ĂF Days Hours NEW YORK Yrs. 110-03-1214 91 Director Usual Residence of Decedent the Marylend 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 ie marked other then "natural", or itema 23a or 28a-f sho traumatic event, the Medical Expenses must be notified at MARYLAND MONTGOMERY ROCKVILLE 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 20852 UNITED STATES 6105 MONTROSE ROAD Funeral filed within 72 hours efter death 12. Was Decedant Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Yaar or Datas: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1 Never Marriad 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE à 3 Vidowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) OWN HOME HOMEMAKER Hygie permit. Peges 1 end 2 should be flit Deperment of Health end Mentel Hy Important: If item 27 Ie marked oth any injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumema) 17. Fathar's Nama (First, Middla, Last) CELIA LEKSHIN MAX SILVERMAN 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3030 Q STREET, NW WASHINGTON, D.C. CELIA WARD (daughter) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Externoval from State 12/19/99 FALLS CHURCH, VA. KING DAVID MEM. GDNS. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Seprice Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE ROCKVILLE, MARYLAND 20852 and Entire the climate. A complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) & ACUTE CEREBRAL INFARCT 2 HOURS Examiner Physician/Medical Examiner ARTERIOSCLEROSIS GENERALIZED The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Ceuse (Diseese or Injury and attending physician for use es the burie Box 68760. that initiated events resulting in death) Last Dua to (or as a consequence of) signed by the a Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the ceuse of death? Division of Vital Records, P.O. 18 Yes 2 No 3 Probably 4 Unknown HODGKINS LYMPHOMA by 24b. Were autopsy findings aveileble prior to 24a. Was an autopsy Completed peen CARCINOMA DF completion of cause of death? hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Physician: 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital; 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 10 1 Yes 2⊠ No After this funeral 28e. Dete of Injury (Month, Day Yaar) 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation or Attending 1 Natural n 24 hours efter death.

ne Funeral Director: After poletely filled in by the fur-1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homlcide Hospital edical 29e. Certifier 1 To rtifying Physician: To the best of my knowledge, deeth occurred at the time, date end placa, end due to the cause(s) and menner es stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end pleca, end due to the ceuse(s) and manner stated. within 2 To the I To the

State Registrar

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LIPSON STEVEN 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 20 1999

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

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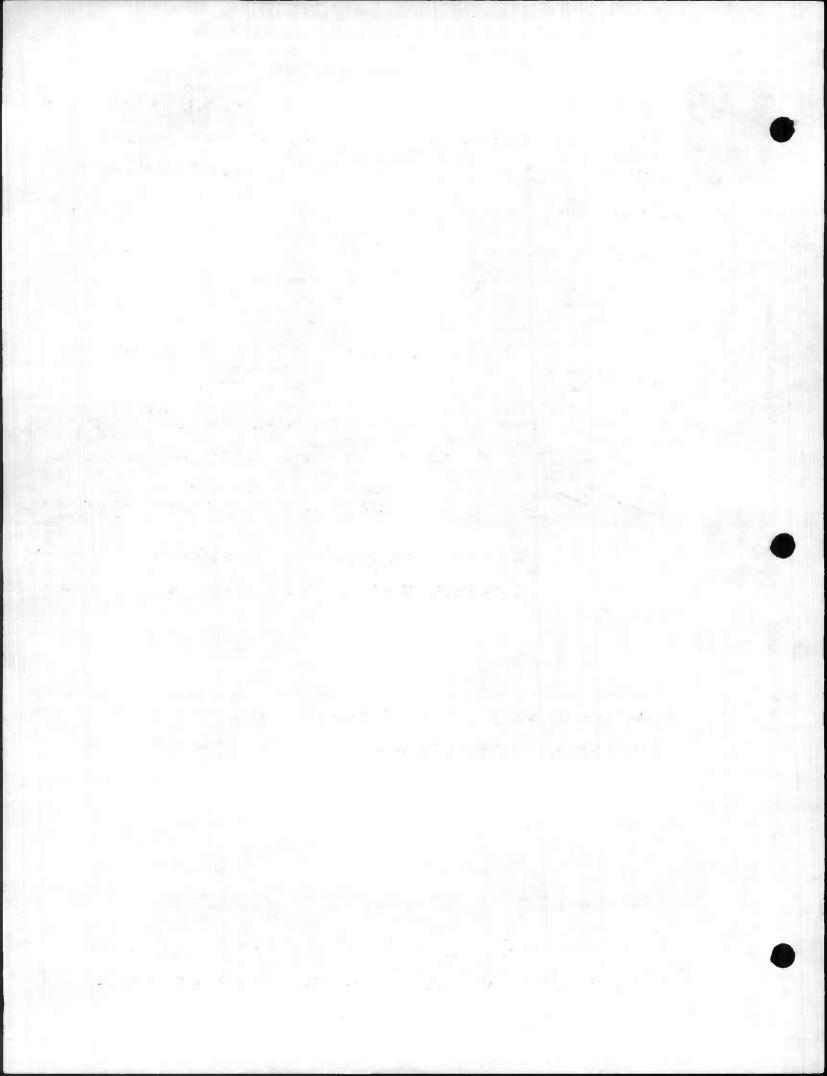
29b. Signature and title of certifier

6121 MONTROSE LOAD, ROCKVILLE, MD

29c. Licensa number

05885

29d. Date signed (Month, Dey, Year)



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Day 22, 1999 Physician Willard Lee Alder, Sr. December 11:31 a.m /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 180 M 2□ F Yrs. 577-16-3996 89 March 14,1910 Maryland Director Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits show must be notified at Maryland Prince George's College Park 1⊠Yes 2□No Directo 288-10e, Street and Number 10f. Zin Code 10g, Citizen of What Country? "natural", or flams 23a or 5108 Kennesaw Street 20740 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Cowboy Ranch permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Joseph Alder Adda Mae Dean 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) Douglas T. Alder - Son 5108 Kennesaw Street, College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from Stele Metropolitan Crematory 12/23/99 Alexandria, Virgina 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility
Gasch's Funeral Home 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** days /Medical Immediate Cause (Final GASTROINTERTINAL BLEEDING disease or condition resulting in deeth) Examiner Due to (or es e consequence of): GASTRIC ULER physician and the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown estric MUX signed b P 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: after death. Director: After this certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospitel: 1 Nnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending 1 Netural 1 Yes 2 No Investigation 2 Accident 6 ☐ Could not be 3 ☐ Sulcide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide hours a 24 hours Funeral 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. To the I 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) December, 22 me 1995 53411 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) 3060 mitchellville Ad # 103 Bome 20 716, Jagdish Shesadri, M.D. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 2 3 1999 Registrar

DHMH 16 Rev 6/95

from the freeze

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State of Maryland / Department of Health and Mental Hygiene 9 4 1 9 3 5

			Certifica	te of Death	Re	ig. No.	1000							
	1. Decedent's Name (First, Middle, Last)			2. Dete of Death		3. Tima of Death							
Physician /Medical	BRIDIE M	ARIE ANDR		DECEMBER 17, 1999 10:57										
Examiner	4a Facility Name (If not institution, give	street and number)		4b. City, Town, or	10 10 0 11 11 11	4c. County of Death								
	1323 Farmingdal	e Avenue		Capitol	Height	s Prince	George's							
Funeral	5. Social Security Number 6. Se	7. Age (In yrs	Month	er 1 Year If Under 24 Hrs B Days Hours Min.	(Month, Day,	Year) 9. Birth Con	nplaca (Stete or Foreign untry)							
Director	578-30-3305 Usual Residence of Decedent	**	76 113.		pct. 8,	8, 1923 _{Virginia}								
B # 1	10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Limits							
Mary med an	MD Prince G	eorge's Ca	pitol He	ights			1 Ves 2 No							
ier death with the Maryland Items 23e or 28e-f show the must be notified at uneral Director	10e. Street and Number 1323 Farmingdal	e Avenue	10f. 2	ip Code 20743	10	Og. Citizen of What Con								
5 E3 6	11. Marital Status	12. Wes Decedent Ever in U	J.S. 13. Wes Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	pecify Yes or No-	14. Rece - Amer	rican Indien,							
urs after aff. or the by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates:		No Specify:	lo Hican, etc.)	Specify: B	lack							
d vittin 72 hours yajene. The free netural, it in the desire to Completed by	15. Decedent's Edu	cation	16a. Decedent's Us	uat Occupation	4	Industry								
within 7	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	life. DO NOT	vork done during most of wo use retired)		O. n Home								
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ind 2 tel Hygie event, it	17. Father's Name (First, Middle, Last)				me (First, Middle, M	faiden Sumeme)								
aryland 21 should be filed will marked other thy imatic event, me	Eddie P. Bruce			Emma V	alker									
re, Maryland 21 s 1 and 2 should be filled wil Health and Mentel Hygien them 27 is marked other the other treumatic event, the	19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailing Addre	ss (Street and Number or R	ural Route Number,	City or Town, Stete, Z	ip Code)							
1 and 2 1 and 2 Health Health Wher tre	Leo F. Andrews/	Husband	1323 F	armingdale	Avenue	2								
of Healt of Healt of Healt r other 27	20a. Method of Disposition	20b.	Plece of Disposition (A	ame of eights, other place)	Date 2	20c. Location - City or	Town, Stete							
Pegent of mr. H. H. P. Or.	1 ☐ Burial 2 ☐ Cremetion 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	IOIIIUVOI IIUIII SIATO		orial Park		andover,								
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Department of the same	1 Lany W	1. Gratt		and Address of Fedility er Inc., 4925 ngton, DC		rroughs	Ave., N.E.							
	23a. Part1. Enter the disease, or compliant shock, or heart feiture. List only or	ications that caused the dea ne cause on each line.	th. Do not enter the m	ode of dying, such as cardia	c or respiratory arre	est,	Approximate Interval Between							
Physician			7				Onset and Death							
/Medical	Immediate Cause (Finet disease or condition	Ju	rdden	de	alk		2 mos.							
Examiner	resulting in death)	Possible Myo Condeal Information Interes												
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E Series	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dia	beles	Melli	res .	Non Insale	~ 15grs							
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Box eth cert for use		1												
D. E. dee	Part II. Other significant conditions cor	tributing to death but not re-	sulting in the underlying	cause giving in Part I.	23b. Did to	bacco use contribute	to the cause of death?							
cords, P.O. Box requires that the death cert been signed by the ettending should be deteched for use leted by Physician/N	Paris	72 - N/	. O No	er Salter	1 Y	s 2 No 3 Pr	robably 4 Unknown							
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The law requirements that has been a page 2 should Completed					parion		completion of cause of death?							
I Rec					1 □ Y€	s 28 No	1 ☐ Yes 2 ☐ No							
Vital is sicien: The sicien: The certificate irrector, page Co	25. Was case referred to medical			26 Place of De	ath (Check only on									
of Vital Re hystolen: The inscentificate he idirector, page To Be Com	avaminer?	lospital:	ER/Outpatient 3 1	Other		nce 8 Other (Spec	oifu)							
0 5 5	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?		w Injury occurred	ary)							
ding ding	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No										
Division of Vita Ital or Attending Physicien: ins effect death. el Director: After this certificate in by the funeral director, Certification: To Be (3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, ferm, street, facto	ory, office	28f. Location (St.	reet and Number or Ru	iral Route Number,							
Oiv offer and offer of the offe	4 ☐ Homicide determined	building, etc. (Speci		7, 5,100	City or Town	, State)								
The supplies	29a, Certifier 12 Cartifying Phys	ician: To the best of my kno	nulados dasth courre	d at the time, date and place	and due to the co	use(s) and manner as	etated							
DIVISION O To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:		ner: On the besis of examination and manner stated.	ation end/or investigation	on, in my opinion, death occ	urred at the time, da	ate end pleca, and due	to the cause(s)							
Me the	29b. Signature and title of certifier	A stated.	2	9c. License number	2	9d. Date signed (Montl	h. Dav. Year)							
FIFE	Ma	Mary		016293	MD	12/22	199							
6	\\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\.\	(0)		70		-//								
(4)	30. Name and address of person who co		m 23a) (Type, Print)	130 Landov	er Road									
	Revathy Murthy,			heverly, M	D_20785									
State Registrar	31. Date filed (Month, Day, Year) OFC 2 2 1999	32 Registrar's Sign	ature											

DHMH 16 Rev 6/95

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MU() 31. Dete tiled (Month, Dey, Year)

DEC 2

30. Neme end address of person who completed causa of death (Item 23a) (Type, Print)

1999

32. Registrar's Signeture

111 Penn Street, Baltimore, Maryland 21201

29c. License number

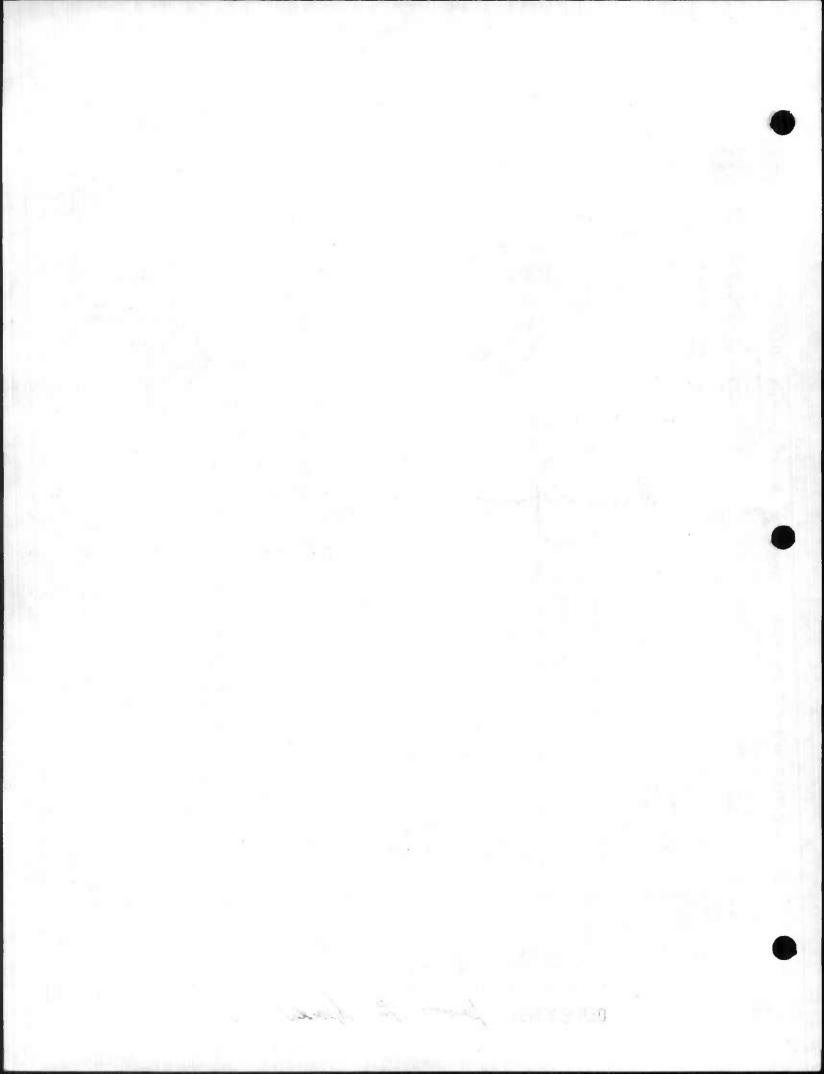
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29d. Date signed (Month, Day, Year)

DECEMBER 20, 1999

Registrar

29b. Sig



AMENI		Binder EMS: #23 PART I	State of Ma , 27, 28	aryland PE	epartment Certificate	of Health and of Death		giene 9 R. 9	9 41937				
Dhu	dalam	1. Decedent's Name (First, Middle, Last					2. Dete of De Month	ath Dey	3. Time of Death				
/Me	sician edical miner	Richard 4a Facility Name (If not Institution, give	Clark street and number)	Bin	der	4b. City, Town,	December or Location of Deet	er 31, 19	999 9:55 A.M.				
A.		Charlotte Hall Mot	el			Charle	otte Hall	St. I	Mary's				
Fune Direct		213-90-7101	7. Ag	e (In yrs. last birtl	nday) If Under Months		Ain (Month De	v Voori	9. Birthplace (State or Foreign Country) Maryland				
dand tand		Ususi Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits				
death with the Meryland ime 23a or 28a-f show	tor	Maryland St. Mar	/'S	Mechani	csville				1 ☐ Yes 2 ☒ No				
th the	Director	10e. Street and Number			10f. Zip	Code		10g. Citizen of W	Thet Country?				
ith wi	lai	28405 Charles Str	eet			20659		US	3. Tima of Death 1. 1999 9:55 A.M. Country of Death St. Mary's 9. Birthplace (State or Foreign Country) 1965 Maryland 10d. Inside City Limits 1 Yes 2 No No A 14. Race - American indian, Black, White, etc. Specify: White Ind of Business/Industry Union Sumeme) ia Bragg or Town, State, Zip Code) laryland 20659 ocation - City or Town, State lardtown, Maryland Ome, P.A. Yland 20650 Approximate Interval Between Onset and Death Onset and Death Onset and Death The PATH OF A Approximate Interval Between Onset and Death The PATH OF A Approximate Interval Between Onset and Death The PATH OF A Approximate Interval Between Onset and Death The PATH OF A Approximate Interval Between Onset and Death The PATH OF A Approximate Interval Between Onset Interval				
9 2 2	by Funeral	11. Meritel Stetus 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Yeer or Dates:		13. Was Deced If Yes, spec	ent of Hispanic Origin ify Cuban, Mexicen, P [X] No Specify:	? (Specify Yes or No uerto Rican, etc.)	Black	k, White, etc.				
2 hou	Pe	15. Decedent's Edu	cation	16a. l	Decedent's Usua	Occupation		16b. Kind of Bu	siness/Industry				
Z1Z Ziene giene. er then	Completed	(Specify only highest grad Elementary/Secondary (0-12) 12th Grade	College (1-4or 5	5+)	Welder	k done during most of e retired)							
C 2 E S	Be	17. Fether's Neme (First, Middle, Last) John Joseph	Bin	der, II		18. Mother's Myrtl	Name (First, Middle C	ecelia					
end 2 sho eath and 27 is m		19a. Informant's Name/Relationship (T) William Patrick McWilli			_								
Baltimore, Maryla Demit. Pages 1 end 2 should Department of Health and Men Important: If Hem 27 is merke Inty Injury or other treumstic.		20e. Method of Disposition 1X Buriel 2 Cremation 3 F 4 Donation 5 Other (Specify)	emovel from State	cemeter)	Disposition (Nemor, cremetory or or of Memorial (ther piece)	1/4/2000						
Departir. Departir Importa	once.	22. Name and Address of Fecility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650											
Physicia		23a. Part1. Enter the disease, or compleshock, or heert failure. List only or	ne cause on each li		ot enter the mode	e of dying, such as ca			Approximete Interval Between				
/Medic Examin		Immediate Cause (Final / disease or condition / resulting in death) a. MULTIPLE INJURIES											
pei led	miner)	Due to (or as a c	onsequence of):								
and and I-trai	Exa	Sequentially list conditions, If any, leading to immediate cause. Enter Underlying											
E 04	//Medical	Cause (Disease or injury that initiated events resulting in deeth) Last	l	ÉL									
death death	Cia	Part II. Other eignificant conditions cor	tributing to death h	ut not resulting in	the underlying or	ause given in Part I	23h Did	tohacco use con	tribute to the cause of death?				
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	Be	25. Was case referred to medical exeminer?				26. Place of	Death (Check only	one)					
OT VICE Physician: This certific ral director,	10	1⊠ Yes 2□ No	lospital:	-			ng Home 5 Resi		ar arene				
LIVISION OF the Hospital or Attending Ph hin 24 hours after death. the Funeral Director: After th mpletely filled in by the funeral	Certification:	27. Manner of Death 1 Naturel 2 Accident 3 Suicide 4 Homicide	28a. Dete of Inju (Month, Da 12-31- 28e. Placa of Inj	y Year) 99 9: 1	55 M	8c. Injury at Work? 1 ☐ Yes 2 ☐ No , office	WALKEI	Street and Numb	E PATH OF A				
or Atte	-		- Dunding et	c. (Specify)			City of 10	wn, Stete) KIH	I IVI'AR GUILI				

Division of Vital Records,

111 Penn Street, Baltimore, Maryland 21201

28d. Describe how injury occurred DECEDENT
WALKED IN THE PATH OF A

28t. Location (Street and Worder of Author Bother Number of Author Numbe

29b. Signature and title of certifier

29c. License number O.C.M.E. 29d. Date signed (Month, Dey, Year) January 01, 2000

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

Jurid 31. Date filed (Month, Dey, Year)

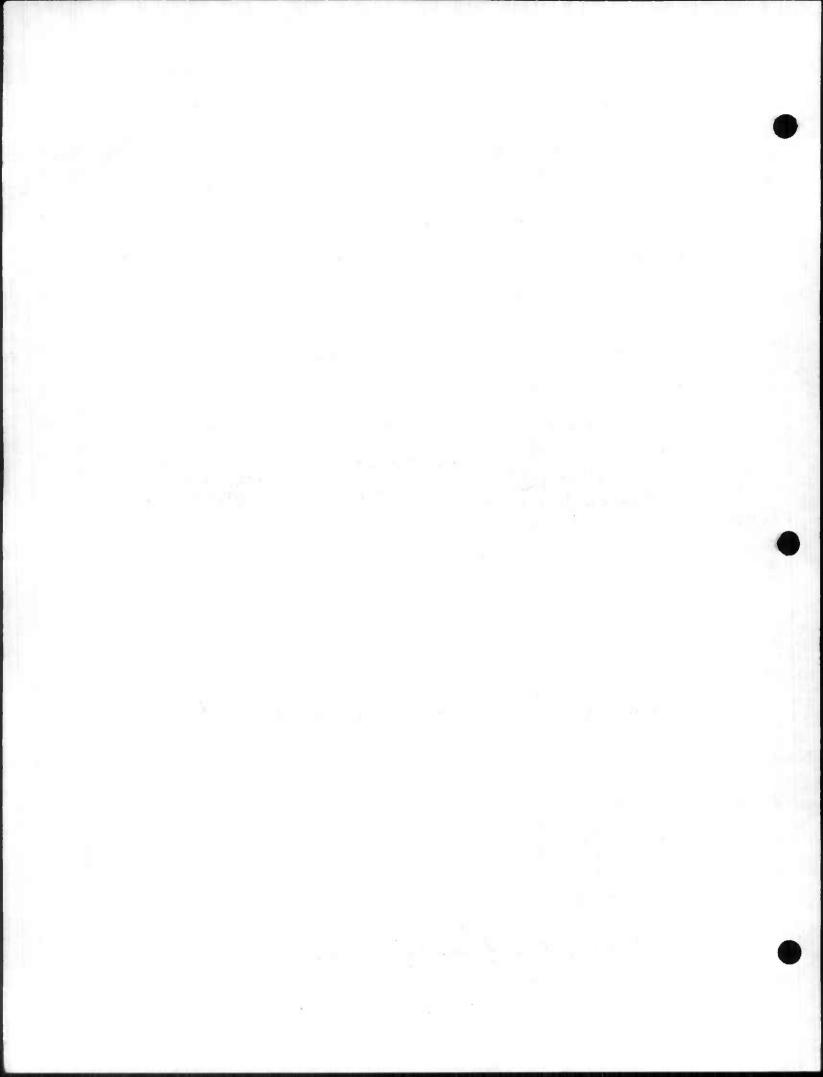
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32. Registrar's Signature

State Registrar

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		Decedant's Nama (First, Middla, L.)	ast)	Ce	rtificate of	Death	2. Data of De	Reg. No.	-}	2 Time of Death				
Physic	ian						Month	Day	Yaar	3. Time of Death				
/Medi		James Welling 4a. Facility Nama (If not institution, gi		KER		4b. City, Town, or I	Dec. 1			5:23 AM				
Exami	ner								y of Death					
		Dennett Road Mano 5. Social Sacurity Number 6.		Home a (In yrs. last birthday)	If Undar 1 Yaar	0aklar		Garrett Oata of Birth						
Funeral Director		220-16-6049	1⊠M 2□F	Van	Months Days	Hours Min.	(Month, De	ey, Year)		aca (State or Foraign				
rector	١.	Usuat Rasidanca of Decedant		74			May 22	, 1925	Mary	Land				
N N		10a. Stata 10b. County		10c. City, Town or Lo	ocation			10d. Insida City Lir						
23a of 25a-f show	to	MD Ga	rrett	Swant	Swanton									
1	Director	10e. Street and Numbar		Owalic	10f. Zip Coda			10g. Citizen of	What Count	ry?				
23a or	0	3412 Swanton Road	ı		215	61		TT	S.A.					
Derros	Funeral	11. Marital Status	12. Was Decedant B		Was Dacedent of I	Hispanic Origin? (S	pacify Yas or No	- 14. Ra	ce - Amarica					
raniner o	by Fu	1 ☐ Nevar Marriad 2 🌠 Marriad 3 ☐ Widowad 4 ☐ Divorced	Armed Forcas? 1 ☑ Yas 2 ☐ N If Yes, Giva Yaar or Datas:	lo	If Yas, specify Cub 1 □ Yas 2 ∏ No	en, Maxican, Puart Specify:	o Rican, atc.)	Specia						
		15. Decedant's E	Education	16a. Dece	dant's Usual Occup	pation		16b. Kind of E	Whi Business/Ind					
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nume	-	19a. Informant's Neme/Ratationship		er, City or Town	MASON , Stata, Zip	Coda)								
r other traumatic		Luella V. Baker/	Spouse	3412	Swanton	Rd Swan	Swanton, MD 21561							
y or othe		20a. Mathod of Disposition 1 X Burial 2 ☐ Cramation 3 [- City or Town, Stata											
Injur		4 Donation 5 Other (Special Standard of Funeral Service Lie		Rose Hil	1 Cemete:	ry	12/22/99	Swanto	n, MD					
any Injury or once.		· Bralley A.	Depul			ass of Facility ST cond St.,								
ician dicai niner	her	Immediata Causa (Final disassa or condition resulting in daath)	e. Cirrh	osis Due to (or es e consed	quanca of):					Onset and Death 6 years				
el-transit	Examiner	Sequantially list conditions, if eny, leading to immediata cause. Entar Underlying Causa (Disaase or injury	b	Due to (or as a consec	quence of):									
es the buriel-trans	edical	Cause. Entar Underlying Causa (Disaase or injury that initiated events rasulting in death) Last	c	Dua to (or as a consec	uanca of):									
d for use es th	Physician/M		d											
by the tached	ıysi	Pert II. Other significant conditions					- • 4	/ _		the cause of death?				
ep ec	by	bipolar disord	er, diabet	es mellitu	s, Parki	nsonsim	11	YPA 2 X No	7	abiy 4 Unknowr				
e 2 should	Completed							an autopsy ormed?	con	ra autopsy findings liable prior to aplation of cause eath?				
peged	O						1□	Yas 2 No	1 🗆	Yes 2□ No				
,	Be	25. Was casa rafarrad to medical				26. Piaca of Dea	th (Check only	ona)						
direct	To	exeminer? 1 ☐ Yas 2 ☑ No	Hospital: 1 ☐ Inpatiar	nt 2 ER/Outpatier	nt 3 DOA Oth	har: 4 Nursing H	ome 5 Rasi	dance 6 Otl	her (Specify)				
ne funeral		27. Mennar of Daath 1 ☑Naturei 5 ☐ Panding 2 ☐ Accidant invastigatio	28a. Data of injur (Month, Day	Year) 28b. Tima o Injury	Wo	43-		how injury occu-						
ed in by the tu	Certification:	3 Suicida 6 Could not l 4 Homicide determined	28e. Piace of Inju building, etc	ry - At home, farm, str . (Spacify)	aat, factory, office		28f. Location (City or To	Street and Num wn, Steta)	ber or Rural	Routa Number,				
tely fill	edical (29a. Cartifier 1 Cartifying Pt (Check only one)	hyalclan: To the best o minar: On the basis of and mannar stat	examination end/or in	n occurrad at tha til vastigation, in my o	ma, data and piaca opinion, deeth occu	, and due to tha rrad at tha time,	ceusa(s) and m date end place,	annar as sta end dua to	ated. tha cause(s)				
comple	Me	29b. Signature and title of certifier	/	/	29c. Licans	sa number		29d. Deta signa	ad (Month, D	Pay, Year)				
0		1 Mares	vot to	6 - 11	\									
		30 Name and address of according	completed and	oth /har one	D266	550		12/20	0/99_					
A		30. Nama and addrass of person who												
		Dr. Margart A. 31. Data filed (Month, Day, Yaar)		r's Signetura	.0. Box 4	186, Oakl	and MD	21550	_					
Sta Registi	-	DEC 991		general &.	Loon	the state of the s								



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Correc

Physic /Med Exam

Funera Directo

treumstic event, the Medical Examiner must be notified at

Completed

Be

death with the Manylend or items 23s or 28s-f show

permit. Pages 1 and 2 should be filed within 72 hours effer begontment of Health and Mentel Hygiene. Important: If Item 27 is marked other than *natural any Injury or other transmission.

Elsie V

-02	23														
_	ginia Bowe	ers	State of	Print in Blac of Maryland / [Эера	rtmen	t of I	lealth a	and N	_				193	9
tio	n item 5	per F.D.	1/3/00	cs	Cer	tificat	e of	Death			Reg	g. No.			
ian	1. Decedent's Nam	ne (First, Middle, Las	sf)							2. Date o Month		Day	Year	3. Time	of Death
cal	Elsie V	irginia B	OWERS							Decer	nber	22,	1999	6:35	A.M.
ner		of institution, given						4b. City, To Oak.		ocation of C	eath	4c. Count			
	5. Social Security N	5066	ex □M 2₫F	thdey) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date o (Month	, Dey, 1	Dey, Year) Country)				
	Usual Residence of	of Decedent													
ctor	10a. State MD	10b. County Garr	ett	10c. City, Tow										10d. Inside	City Limits
Dire	10e. Street and Nu 303 Pys	mber ell Cross	7	10f. Zip Code 10g. Citizen of What Country? 21550 USA							intry?				
						3. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2☑ No Specify: 11□ Yes 2☑ No Specify: Specify: White									

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Lambka Annie Myrtle Studt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Joan R. Bowers/Daughter 20 king's Run Road, Oakland, Maryland 21550 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Omega Crematory 12/27/99 Morgantown, WV 22. Name and Address of Facility 21. Signature of Fugeral Service Licenses Stewart Funeral Home

Physician /Medical **Examiner**

detached for

funeral director, page 2 should be

Be Completed by

Medical Certification: To

signed by

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

after death. Director: After this

within 24 hours a To the Funerel D

To the Hospital

completely filled in by

Physician/Medical Examiner The law requires that the death certificata be executed use es the bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last the attending physician

Immediate Cause (Final disease or condition resulting in deeth)

32 S. Second St., Oakland, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Hours Years diava Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Wunknown

24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy performed?

2 No

25. Was case examiner	referred to medical
1 TYes	2 No

Hospital: 1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

ATI

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Bother (Specify) at scene

2 No

27. Manner of Death 1 Natural 5 Pending Accident
3 Suicide investigation 6 Could not be

28a. Date of Injury (Month, Dey

Injury 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Subject .es entironante WASSCHI

29e Certifio

4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signat and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Dey, Year) December 23, 1999

impleted cause of death (Item 23a) (Type, Print)

LAREN (C) Lex MO

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 41940 State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 21, 1999 John Francis Coster 3 55 PM Dec 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street and number) 4c. County of Deeth Solomons Nursing Center Solomons Calvert If Under 1 Year If Under 24 Hrs. Months Devs Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sax 7. Aga (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Deys Hours TSØM 2□ F Yrs. 056 01 5629 95 Feb 25 1904 Maryland Usuel Residence of Decedent 10c. City, Town or Location 10e. Stete 10b. County 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 955 Ed Joy Road 20657 United States 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 14. Raca - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yes 2 ☐ No Specify: Specify: **∛**□ Widowed 4 □ Divorced white 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 12 general merchandise store owner 17. Fether's Neme (First, Middle, Last) Frank S. Coster Clara V. Sweitzer 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zlp Coda) 19a. Informent's Name/Reletionship (Type, Print) Virginia Joy - daughter 955 Ed Joy Road Lusby MD 20657 23 99 Sea 20b. Pleca of Disposition (Name of cemetery, crematory or other place) Our Lady Star of the 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 ☐ Cremetion 3 ☐ Removal from State Solomons Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Rausch Funeral Home PA 4405 Broomes Is. Rd. Port Republci MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between 7 6 Onset and Deeth Immediate Cause (Finel disease or condition resulting in deeth) CARCINOMA PROSTATE Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a conseguenca of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 25 No 3 Probably 4 Unknown heart 24b. Were eutopsy findings aveileble prior to 24a. Wes en eutopsy pertormed? completion of cause of death? 1 ☐ Yes 2 PNo 1 TYes 2 No. 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2500 1 Inpatient 2 ER/Outpetient 3 DOA 28a. Dete of Injury (Month, Day Year) 28c. Injury et / Work? 27. Manner of Deeth 28d. Describe how Injury occurred 28b. Time of Maturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicida 28f. Location (Streat and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, ferm, straet, fectory, offica building, etc. (Specify) 4 - Homicide

certificate be axecuted attending physician and for use as the bunal-tran Box 68760, use as t P.0. 3 Division of Vital Records, page 2 certificate this lunerel After or Attending

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Funeral

Director

Item 27 is marked other than "natural", or items 23a or 28a-f abov other treumstic event, the Madical Examiner must be notified at

2 should be filled within 72 hours after on and Mentel Hygiane.
Is marked other than "natural", or item

permit. Pages 1 end 2 st Department of Health end Important: If Item 27 Is n

Physician

/Medical

Examiner

any injury or o

altimore, Maryland 21215-0020

the Marylend

death

Physician/Medical þ Completed Be Lo Certification:

Examiner

edicai

s efter death. 6 within 24 hours of To the Funeral C Hospital completely

29b. Signature and title of certifier SIRM

(Check only

29c. License number

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.

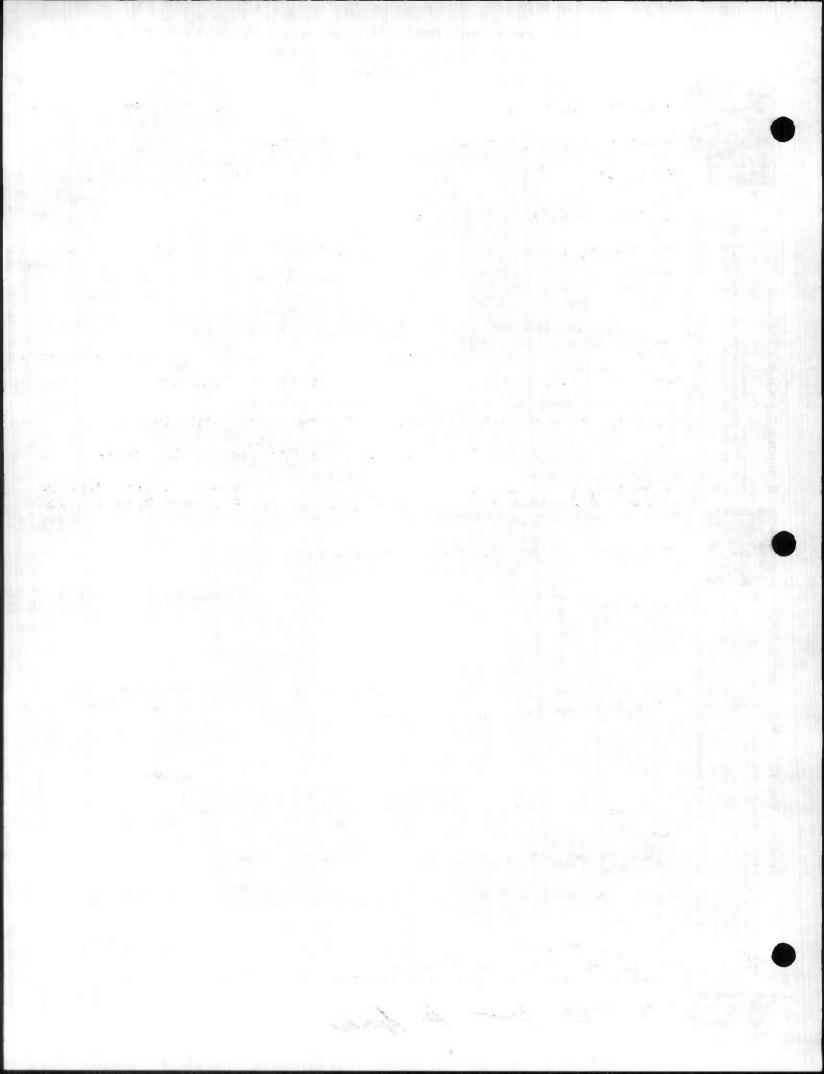
Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner steted. 29d. Data signed (Month, Day, Year) 12/22/99

mis 2065

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) TRVEMEN RD LUSBY MATHEW MD, 11910 H. G

State Registrar 31. Dete tiled (Month, Day, Year) DEC 2 7 1999 32. Registrer's Signeture

Sporks



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene QCertificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) December 20 1999 SHARON DANIELS GAY 1:00 a.m. 4b. City, Town, or Location of Deeth 4c. County of Death 4e Facility Neme (If not institution, give street end number) 3825 Yellow Bank Road Dunkirk Calvert If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) Months Deys Hours 1□M 2♥F 219 36 8778 61 Yrs July 27,1938 Longmont, CO Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d, Insida City Limits 1 Yes 2 No Dunkirk Calvert Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20754 USA 3825 Yellow Bank Road 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Y Year or Detes: Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Maritel Stetus Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: white 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elamantary/Secondary (0-12) printing bookkeeper 12 18. Mother's Neme (First, Middla, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Vernetta Carr Daniels Harold 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Ralationship (Type, Print) same as # 10 above Sandra J. Wheeler / sister 20b. Pleca of Disposition (Neme of cametery, cremetory or other pleca) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 【Cremetlon 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 12-21-99 Alexandria, VA Metropolitan Crematory 21. Signeture of Funeral Service Licanses 22. Name end Address of Fecility C Rausch Funeral Home, P.A., Owings, MD 20736 W ations thet caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, cause on each line. 23e. Pert1. Enter the disease, or complic shock, or heart feilure. List only one Approximata Interval Between Onset end Death cinnhosis Immediate Ceuse (Finel disease or condition resulting in daath) Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disaesa or injury thet initiated events resulting in deeth) Lest Due to (or es e consequance of): Due to (or es e consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Hypertersion 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24a. Was an eutopsy 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Othar: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify)

Physician /Medical Examiner

thet the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Directo

Funeral

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Completed

2

Funeral

Director

from 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Madical Examinar must be notified at

permit. Peges 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiena. Important: If item 27 is marked other than "natural", or items 23a and injury or other traumatic event, the Medical Examiner mast and DEG.

altimore, Maryland 21215-0020

with the Maryland

physician end the burial-trensit Ses usa 0 signed by the e page 2

Examiner Physician/Medical g Completed Be 2 funeral Certification: To the Hospital or Atterwithin 24 hours after dea To the Funeral Director completely filled in by th

hes

certificate

Hospital or Attending Physicien:
 24 hours after death.
 Funeral Director: After this certifica

25. Was cesa raferred to medical exeminer? 1 Yes 2 No 27. Mannar of Death Naturel 5 Pending 2 Accident

4 Homicida

31. Dete filed (Month

Investigetion 6 Could not be determined 3 Sulcide

28a. Data of Injury (Month, Day Year) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury et Work? 1 ☐ Yas 2 ☐ No

28d. Describe how Injury occurred 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata)

Certifying Physician: To tha best of my knowledga, daath occurred et the time, date end pleca, end dua to tha causa(s) and manner as stated.

| Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) end menner stated. 29a. Certifier 29d. Date signed (Month, Dey, Yeer) 29b. Signature-47th title of certifie 29c. License number

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

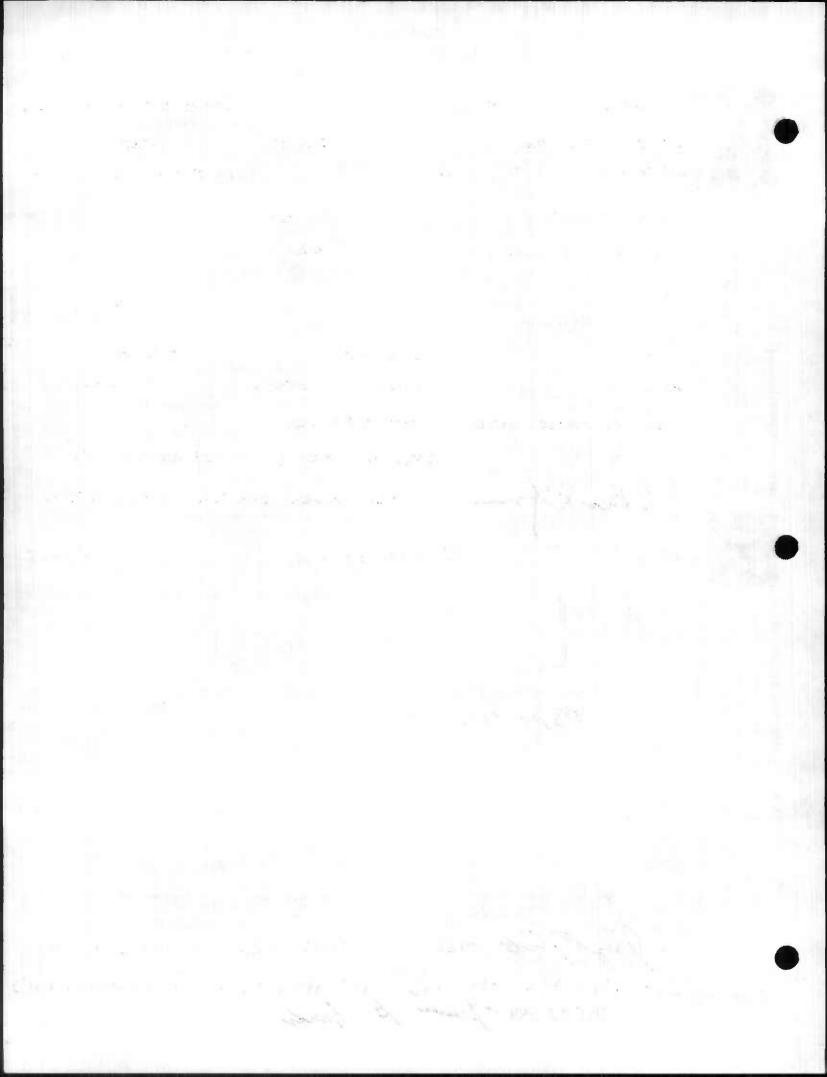
DEC 2 3

Elensu, 21, 1999

State Registrar

edical

110 Hospital Rd Prince Fred. mD 32. Registrar's Signatura 1999



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Time of Death 2. Date of Death Month Easton Viola M. 1999 21, 1630 December 4e Facility Neme (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis

If Under 1 Yaer

Days

Months

If Under 24 Hrs.

Hours

7. Age (In yrs. last birthday)

80

8. Dete of Birth (Month, Day, Year)

May

1919

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset end Death

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 Yes 2 No

Maryland

Funeral

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

5. Social Sacurity Number

217-82-1900 Usuel Residence of Decedent

10a State

6 Sax

10b. County

6 Could not be

30. Name and address of person who completed cause of deeth (Item 23a) (Type,

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature end title of

ERRO

1□M aXX

Director with the Maryland "natural", or from 23a or 28a-f show filed within 72 hours after al Hygiene.
d other than "natural avant, the Medical F

.. Pages 1 and 2 should be filed vitment of Health end Mental Hygie tant: If ham 27 is marked other thury or other traumatic avant, at Department of important: If it any injury or o

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

Completed by Physician/Medical Examiner the bunal-transit USB 85 Certification: To Be After this funeral

The lew requires that the death certificate be executed Physician: or Attanding r death. within 24 hours after deat To the Funeral Director: filled in by Hospital the state

Box 68760, P.O. Records, Division of Vital

10c. City, Town or Location Maryland Tracys Landing Anne Arundel 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20779 USA 6228 Franklin Gibson Road 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Race - American Indian, Black, White, atc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Merried 2 ☐ Merried Specify: Black 1 ☐ Yes ŽXNo Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Someone Else's Home Domestic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Whittington Mattie Gray Henry 19e. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Dorsey/Daughter P.O. Box 74 Tracys Landing, MD 20779 20b. Plece of Disposition (Name of cematery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removel from Stete 12/27/99 Huntingtown, MD 4 ☐ Donation 5 ☐ Other (Specify) Bethel Way of the Cross 22. Nama and Address of Fecility Sewell Funeral Home 21. Signeture of Funerel Service Licenses elex 1451 Dares Beach Rd. Prince Frederick, MD 20678 4. 23a. Pert1. Enter the disaase, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heer tailure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Disease or Injury Due to for as a conthet initiated avents resulting In deeth) Lest Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No. 3 Probably 4 Unknown NOORS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 25 NO 25. Was case reterred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpalient 2 ER/Outpatient 3□ DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death
Netural
Accident 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

Registrar

State

edical

28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify)

32. Registrar's Signeture

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29c. License number

and the formation of the same to the same

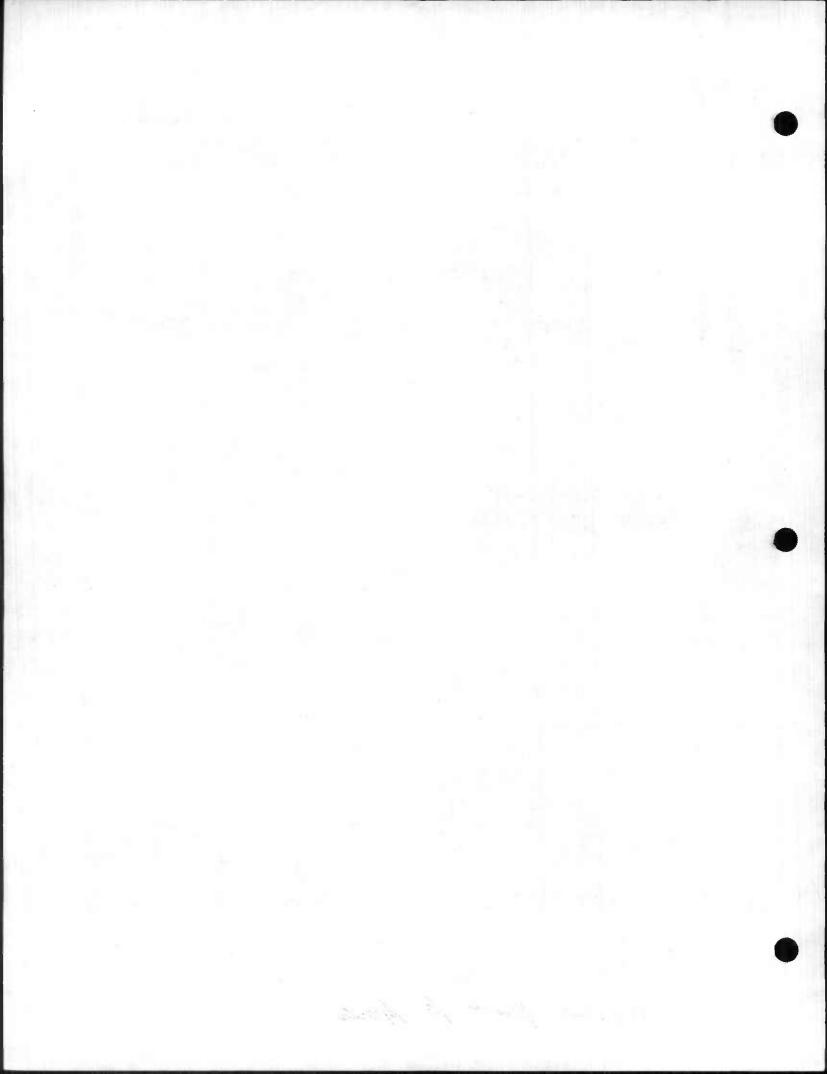
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

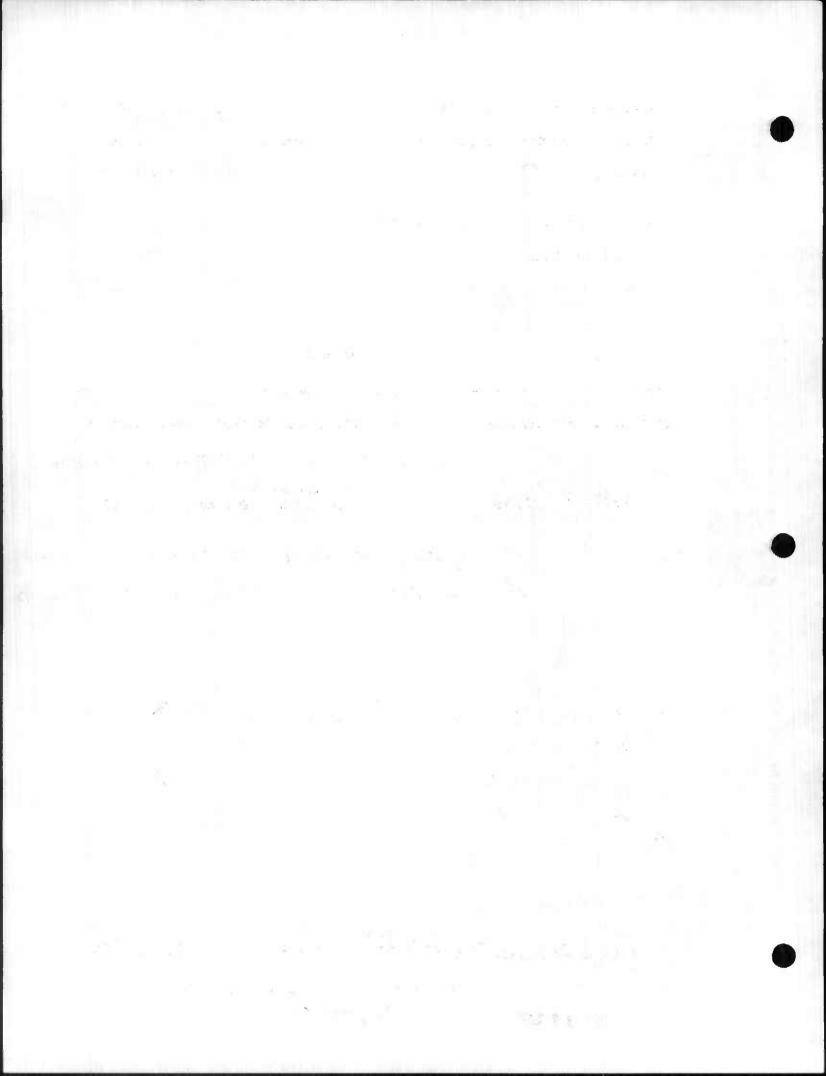
		olato ol marytar	Certifi	cate of Death		Reg. No.	41943				
Dharista	1. Decedent's Name (First, Middle, Las	ot)			2. Date of De Month		3. Time of Death				
Physician /Medical Examiner	JULIUS 4a Facility Name (If not institution, give	DORSEY street and number)		FISHER 4b. City, Town,	DECEM), or Location of Deat	BER 22,	1999 00:45am				
Examine.	Calvert Memorial	Hospital			Frederick	Calv	vert				
Funeral Director	5. Social Security Number 6. State of the security Securi	9x 7. Age (In yrs. 87		Under 1 Year If Under 24 nths Deys Hours M	Hrs. 8. Date of Bir (Month, Da Nov. 2	th ly. Year) 24, 1912	Birthplace (State or Foreign Country) MD				
and w	10a. State 10b. County	10c. Cit	y, Town or Locatio	n			10d. Inside City Limits				
Mery and	MD Calver	t Br	oomes Is	land			1 ☐ Yes 2♣ No				
th with the Mer 23s or 28s-fall at Director		d	10	Of. Zip Code 20615	5	10g. Citizen of W	hat Country? USA				
d 21215-0020 filed within 72 hours after death with the Meryland hygiene. ther than "natural", or frems 23s or 28s-f show int, the Medical Exercise must be notified at a Completed by Funeral Director.	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 Tyes 2 No. 142- HYes, Give Year or Dates:	S. 13. Was if Yes	Decedent of Hispanic Origin, specify Cuban, Mexican, Power of the Communication of the Commun	? (Specify Yes or No uerto Rican, etc.)	14. Race Black Specify:	- American Indian, s, White, etc. White				
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hygiene. The marked other than "natural", or traumatic avent, the Medical Exert To Be Completed by F	15. Decedent's Ed (Specify only highest grant Elementary/Secondery (0-12)	ucation de completed) College (1-4or 5+)		Usuet Occupation of work done during most of OT use retired)	working	16b. Kind of Bus					
d 212 filed withi Hygiene. ther than ant, tree	12 17. Father's Name (First, Middle, Last)		carpe		Name (First Middle		ruction				
Viand Suid be fil Mental H inked out		I	Sisher		Name (First, Middle, Maiden Surname) orence Dorsey						
	19a. Informant's Name/Relationship (7 Mary Jane Fisher			ailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ame as 10 above							
₩ -155	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	(Name of y or other place) Cemetery	Date 12-27-99		city or Town, State					
Baltimol permit. Pages Department of important: If heary Injury or o	21. Signature of Funeral Service Licen	see Bell		ne and Address of Facility sch Funeral H	I		Is. Rd.				
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications thet caused the deat	h. Do not enter the	mode of dying, such as car	rdiac or respiratory e	rrest,	Approximete Interval Between				
Physician /Medical Examiner	Immediate Ceuse (Finet disease or condition resulting in death)		erminia			<u> </u>	Onset and Death				
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ovecuted and isl-transit	Sequentially list conditions.		1 x /2-1/2								
50, se exe clan a surial-l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	c					1				
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Deer per per per per per per per per per						an autopsy primed?	24b. Were sutopsy findings available prior to completion of cause of death?				
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Divisor To the Hospital or Atla within 24 hours after de To the Funeral Directo completely filled in by the Medical Certific		rsician: To the best of my kno Iner: On the basis of examina and manner stated.									
To the comp	29b. Signature and title of certifier			29d. Date signed	(Month, Day, Year)						
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	30. Name and address of person who con DR.PAUL POMILI		n 23a) (Type, Print) NCE FRE		20678						
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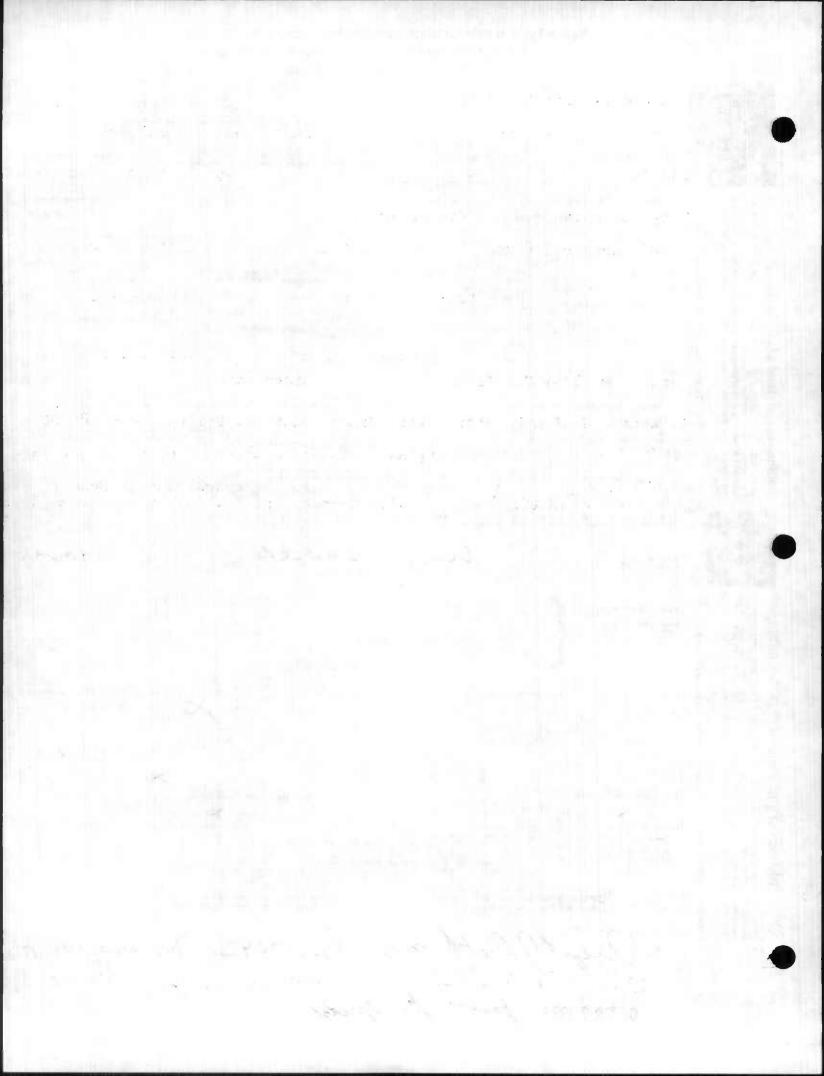
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Baltim permit. Pag Department Important: I any Injury o		gnatura of Fu	0.0	A 1-4	11				2 torre	-	ass of Facility Funeral	Нот	ne	261	01550			
Physician /Medical Examiner	23a. Part1. Entar tha disease, or complications that ceused tha daath. Do not antar tha mode of dying, such es cerdiec or respiratory arrest, shock, or haart failura. List only one cause on each line. Immediate Causa (Final disease or condition resulting in death) a. Congettive Heart Four (uve Dee to (or as a consequence of): b. Acute Myocava & all Triffers Holler Dee to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Causa (Disease or Injury Causa (Disease or Injur																	
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State	21 De	te filed (Mont					Signatura	ACTE	s Dr	Las	Oakla	nd,	Md. 21	33U				



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 23 1999 **Physician** Edward Vincent Griffith 5 15 PM Dec /Medical 4a Facility Name (If not institution, give street end number) 4986 Sandy Point Road **Examiner** 8. Date of Birth (Month, Dey, Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□ F Months Days Hours Min Yrs. Sept 22 1930 WashingtonDo 69 Director 214 28 8935 Usual Residence of Decedent with the Manylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Prince Frederick 1 TYes MINO Maryland Calvert Directo 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code United States 20678 4986 Sandy Point Road death v Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Biack, White, etc. 11. Maritel Status permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Heelth end Mental Hygiene. Important: If flem 27 is marked other than "natural", or fler eny injury or other traumatic event, the Medical Examinat ty⊡ Yes 2□ No If Yes, Give 52-54 Year or Dates: 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0020 1 Yes 3€ No Specify: Speciffwhite P 3 Widowed 4 Divorced Completed 16e. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 farmer agriculture 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) Be Arthur William Griffith Grace King 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 678 4986 Sandy Point Rd. Prince Frederick MD 19e. Informent's Neme/Reletionship (Type, Print) A. Louise Griffith- wife 20b. Place of Disposition (Neme of cometery, crematory or other place) Dec 30 Pate 99 Cheltenham Maryland Veterans Cemetery Cheltenham Mar 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Cheltenham Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee Rausch Funeral Home PA 4405 Broomes Is. Rd. POrt Republic mD 2076 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Final disease or condition resulting in death) CANCER month **Examiner** Due to (or es consequence of) Examiner physician end the burial-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Box 68760, certificate be Physician/Medical Due to (or es a consequence of): 88 980 signed by the a 23b. Did tobacco use contribute to the cause of death? P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. Y98 2□ No 3□ Probably 4□ Unknown Division of Vital Records, þ 24b. Were eutopsy findings evailable prior to 24e. Wes en eutopsy performed? Completed completion of cause of deeth? page 2 hes 1 Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific 25. Wes cese referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 Sesidence 6 ☐ Other (Specify) 1º 1 Yes 20 No 1 Inpatient 2 ER/Outpatient 3 DOA funerel 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. injury at Work? 27. Menner of Deeth Certification: 1 SNaturei 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) and menner es stated.
2 Medical Examiner: On the besis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner steted. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and tiple of certifier 29c. License number ni 30. Name and address of per son who completed cause of death (item 23a) (Type, Print) Frederick 31. Dete filed (Month, Dey, Year)
DEC 2 7 1999 3. Registrer's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 99 4196

					Ce	rtificat	e of	Death		R	leg. No.				
Physi /Med		1. Decedant's Nama <i>(First, Middle, L</i> Henry	ast)	· F	Hawkin	s				Data of Dear Month ecembe	th Day	Yeer 1999	3. Time of 8:0	15 Th	
Exam		4e. Fecility Nema (If not institution, g Annapolis Nursin			ion C	enter		4b. City, Tow Anna	wn, or Locat polis	ion of Death	4c. County Anne	of Death Arund	le1		
Funera Directo		5. Social Security Number 6. 219-16-2196 Usual Rasidence of Decedant	Sex 1☑M 2□F	7. Aga (In yrs.]	last birthday, 4 Yrs.	If Under Months	1 Year Days	if Undar 2 Hours	Min. Ma	Dete of Birth (Month, Day) 1 C D 4	, 1925	9. Birthpid Count Mary	aca (State of Pland	or Foreigi	
puel Mo		10a. Stata 10b. County		10c. City	, Town or L	ocation						10	d. inside C	ity Limits	
Mery Figh	to	Maryland Anne Ar	unde1		Wes	t Rive	er						1 🗆 Yes	2 No	
h with the 23a or 28a	ai Directo	10e. Street and Number 5167 Sudley Roa	d			10f. Zlp	Coda 2077	78		1	0g. Citizen of USA		ry?		
s 1 and 2 should be filed within 72 hours efter death with the Meryland Fleath and Mental Hyglene. I health and Za or 28e-f ahow tam 27 is marked other than "natural", or items 23a or 28e-f ahow other traumatic avent, the Medical Examiner ment to notify d	by Funeral	11. Marital Stetus 1 Nevar Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes if Yas, Gi	12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes ★ No If Yas, Giva Yeer or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or tt Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yes 2 ☐ No Specify:							Bia	14. Race - American Indian, Biack, Whita, atc. Specify: Black			
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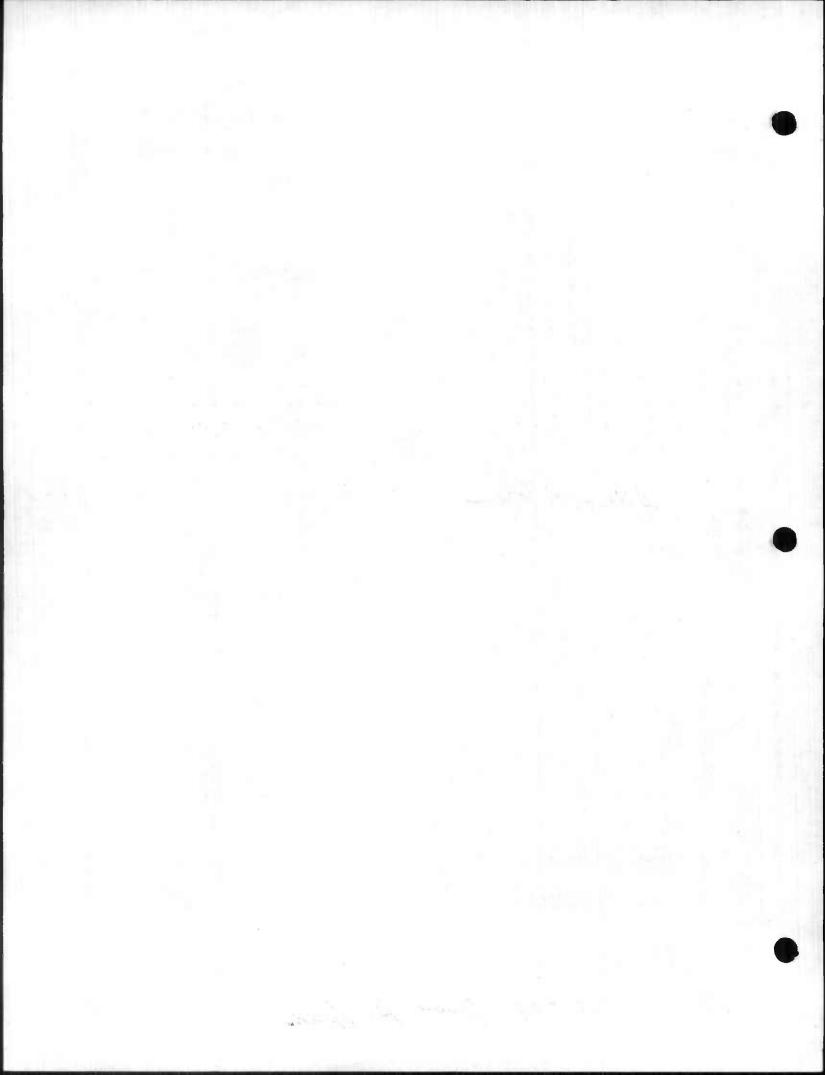
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State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** ROBERT HARDESTY DECEMBER 22,1999 5:30am /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Millenium Health & Rehabilitation Center Edgewater Anne Arundel If Under 24 Hrs. 6. Sex 1X M 2□ F If Under 1 Year 5. Social Security Number 7. Aga (In yrs. last birthday) Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 213 28 1328 Director Nov 21, 1918 Harwood, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "naturel", or items 23s or 28s-f show the Medical Exampler must be notified at Maryland Calvert Sunderland 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 520 Lower Marlboro Road 20689 USA death Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1X Yes 2 □ No
If Yes, Give
Yaar or Dates:1944-46 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Amarican Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2√ No Specify: p 3 ₩ Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grads completed) 16b. Kind of Business/Industry I Hygiena. Elementery/Secondery (0-12) Collega (1-4or 5+) farmer agriculture other 1 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any Injury or other treumatic event abba. Daniel Hardesty Mary Catherine Drury 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 490 Lower Marlboro Road, Sunderland, MD 20689 Hazel J. Webb / niece 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion U.M. Cemetery 12-24-99 Lothian, MD 21. Signature of Funaral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 illiam 23a. Part1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician MURETHAN /Medical Immediate Causa (Final IC CARCINOMA disease or condition resulting in death) mon Ho Examiner MUZETHAN Examiner CANCEIR NG minsh physicien end s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Tyes 2 No hyovic Obstructive Lung Records, 24b. Were eutopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yas 2 ☐ No Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residenca 6 Other (Specify) Hospital: 1 Yes 28 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun 1 Natural 1 Yes 2 No Investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 🆄 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) and menner as stated. edicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, end due to the ceuse(s) and manner stafed. 29d. Date signed (Month, Day, Year) 29b. Signature and fitta of certifian 29c. License number D 50653 ar GYAN C SURAMA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 IVA Deale Church ton Rd Dealo 31. Date filed (Month, Day (Year) 2 7 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death 18 1^{Yee} 18 1999 Month Physician RUTH NAOMI IMER 23:22 December /Medical 4e. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Anne Arundel Medical Center Annapolis . Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5 Social Security Number 8. Dete of Birth (Month, Dey, Yeer) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2X F Hours 88 Yrs. Director 578 12 6376 Feb 5, 1911 Virginia Usual Residence of Decedent the Maryland 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits 28a-f ahow traumatic avant, the Missinal Examiner must be notified at 1 ¥ Yes 2 □ No Director Maryland Calvert North Beach 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? ծ 8908 Bay Avenue 20714 USA items 23e Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Peges 1 end 2 should be filed within 72 hours effer a Department of Health end Mental Hygiene. Important: If Itam 27 is merked other than "natural", or free any Injury or other traumetic even. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: by 3 Widowed 4 □ Divorced white Completed 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) waitress food services 11 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Daniel Grisso Brillhart 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John D. Imer / son 9208 Bay Ave., North Beach, MD 20714 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 12-23-99 Alexandria, VA Metropolitan Crematory 21. Signeture of Funerel Service Licansee 22. Name end Address of Fecility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Pert1. Enter the disease, or compositions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only only cause on each line. Onset end Deeth **Physician** SEPSIS /Medical Immediete Ceuse (Final 1 DAY diseese or condition resulting in death) **Examiner** Due to (or as e consequenca of): 5 DAYS Physician/Medical Examiner PNEUMONIA The law requires that the death certificate be executed physician end s the burial-tran Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initiated events resulting in deeth) Lest P.O. Box 68760, the Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? s been signed by t should be detech ORGANIC BRAIN SYNDROME 1 Yes 2 No 3 Probably 4 ♥ Unknown Records, þ 24b. Were eutopsy findings evelleble prior to completion of cause of deeth? Be Completed 24e. Wes en eutopsy performed? DEMENTIA page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificete Division of Vital To the Hospital or Attending Physician: within 24 hours efter death.

To the Funeral Director: After this cartifice completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medicai Certification: To 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28b. Time of 28d. Describe how Injury occurred Natural 2 Accident 5 Pending Investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and placa, end due to the cause(s) end manner stated. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of cartifier D 50653 12-20-1999. 5851 - Deale Churchton Roaci 30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print) 20751 nu D DEALE

DHMH 16 Rev 6/95

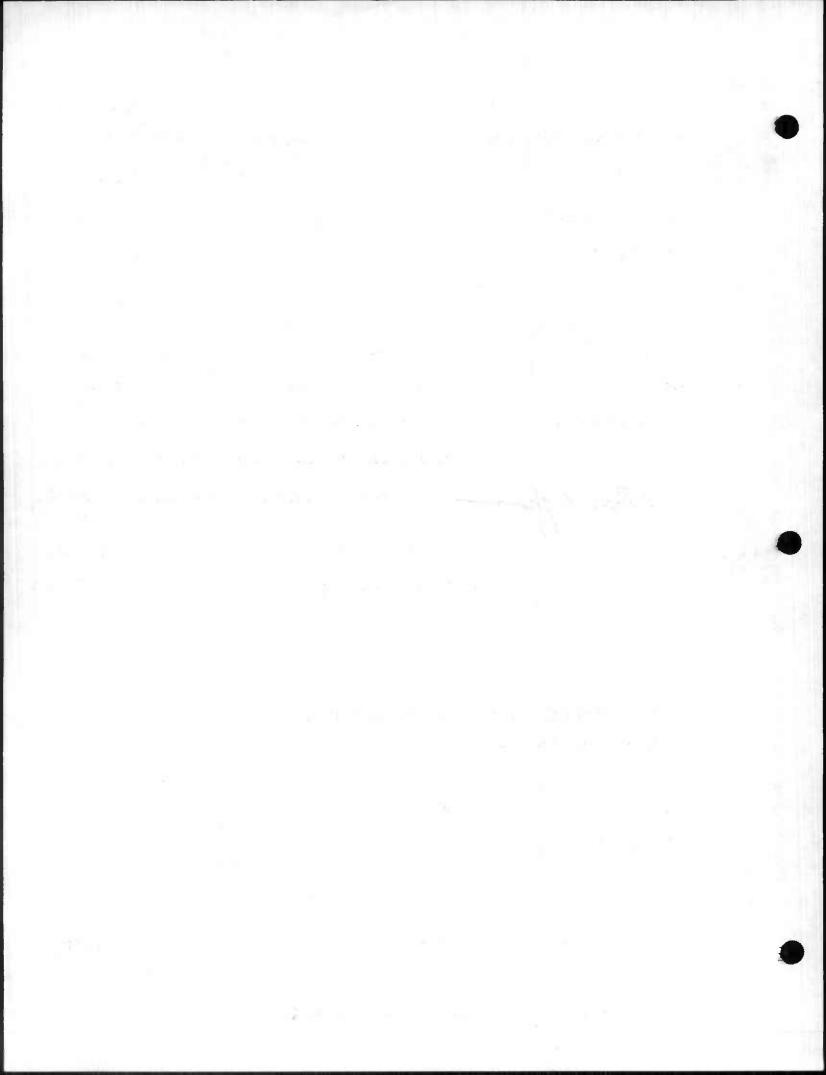
State

Registrar

31. Date filed (Month, Dey, Year)

DEC 2 3 1999

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month William K no Hs SR 0610 PM CHARLES 4a Fecility Neme (If not institution, give street end number b. City, Town, or Location of Deeth 4c. County of Deeth If Under 1 Year 24 Hrs. Birthplace (State or Foreign Country) ial Security Number Ser Age (In yrs, lest birthday) 8. Date of Birth (Month, Dey, Year) Min Months Deys Hours 15€ M 2□ F Yrs 234-40-3228 May 23 1929 W. Va 70 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Garrett Kitzmiller 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 4150 Kitzmiller Rd. 21538 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 1946- 48 14. Race - American Indien, 11. Meritel Status Bleck, White, etc. 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Saw Mill Operator Lumber 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) John Knotts Eula Stemple 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) 4150 Kitzmiller, Rd Kitzmiller, Md Dorothy Knotts 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Garrett Co. Mem. Gardens Dec. 27 99 Oakland, Md 22. Name and Address of Fecility 21. Signeture of Funerel Service Licensing David A. Burdock FH Park. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth CANCER Immediete Ceuse (Final PANCREATIC MUNTHS diseese or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that Initieted events resulting in deeth) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings avelleble prior to completion of cause of death? 24a. Wes en eutopsy 2/3 No 1 ☐ Yes 1 TYes 2 No

Physician /Medicai Examiner

any injury or

Physician

· /Medical

Examiner

Funeral

Director

other traumatic event, the Mesical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours aftar or Department of Health and Mental Hygiena. Important: If Item 27 is marked other than "naturel", or iter

Maryland 21215-0020

Baltimore,

the Maryland

death

5 50

Director

Funeral

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Completed

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10a State

Md

ician and buriel-trans physician the use es t jo page 5 director,

that the death certificate be axecuted

Box 68760

P.O.

Division of Vital Records,

Hospital

within 2 To the

Examiner Physician/Medical Completed Be 2 Certification:

25. Wes case referred to medical exeminer?

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peen has certificete or Attending Physician: this funeral After

signed by the a 24 hours after death.

Funeral Director: Al

> 8+1VA State

Registrar

Medicai

10 31. Date filed (Month, Day, Year)

29b. Signeture end title of certifier

1 Yes 2 No

27. Menner of Deeth

1.2 Neturel

2 ☐ Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

1 Inpatient

28e. Dete of Injury (Month, Dey Year)

29c. License number

26. Piece of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 □Other (Specify)

28d. Describe how Injury occurred

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) end menner es stated.

2 Medicat Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) and menner stated. 29d. Date signed (Month, Dey, Year)

Location (Street and Number or Rural Route Number, City or Town, Stete)

who completed cause of deeth (Item 23e) (Type, Print)

Hospitel:

5 Pending investigation

6 Could not be determined

2 ☐ ER/Outpetient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

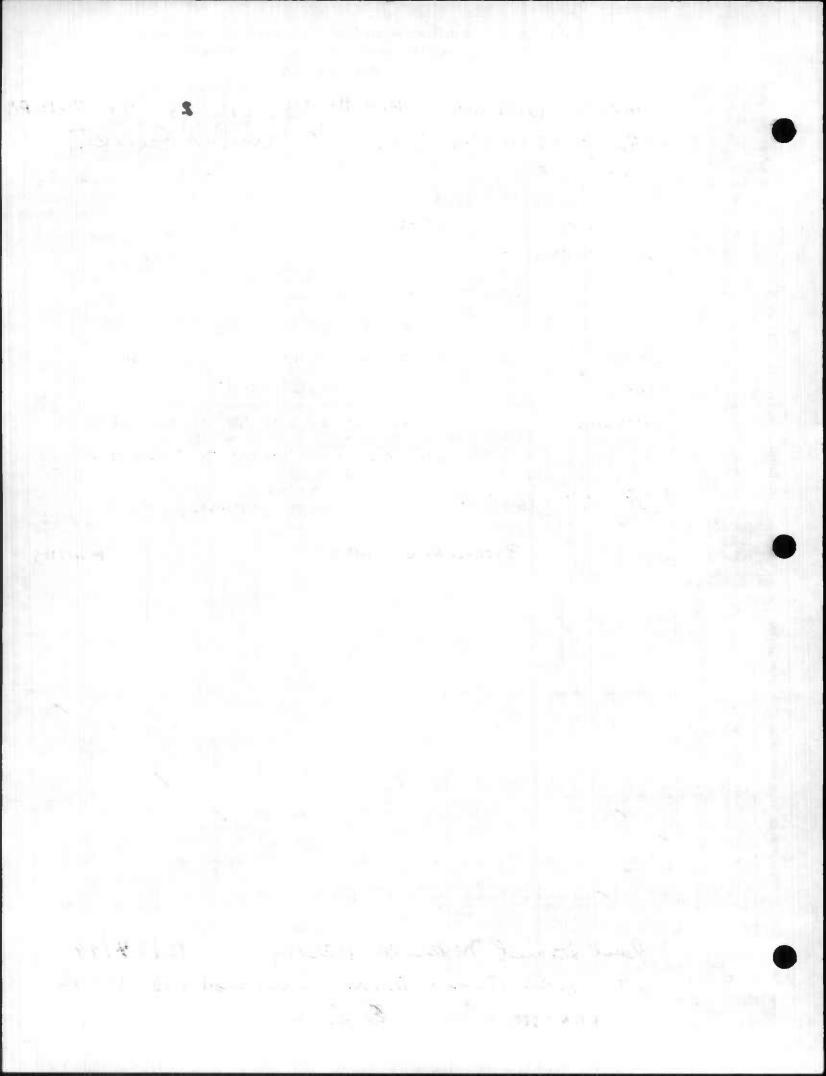
akland MD

32. Registrer's Signeture

28c. tnjury et Work?

1 Yes

2 No



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

3 Time of Deeth

23:01 PM

Birthplece (Stete or Foreign Country)

Production

Wilt

Approximate Intervet Between Onset end Daath

10d. Inside City Limits 1 X Yas 2 No

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Dhusiaia	_	Decedent's Nan	ne (First, Mid	dle, Las	st)								2. Deta of Death Month Dey Yeer					
Physicia /Medica		John	Lenw	boo	LEE								Decem				23:	
Examine		4a. Facility Name ((If not instituti	on, give	e street end num	bar)				- 1	4b. City, To	own, or Le	ocation of De		4c. County			
. Admini	•	Sacred 1	Heart	Hosi	nital						C	umhe	rland		Δ11.	egan	37	
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		217-28-7	628	1	M 2□ F		67 Yr	ast birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Apr. 22, 1932 Max										
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	Director	10e. Street end Nu					10f. Zip Code 10g. Citizen of Wh								Whet Cou	intry?		
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th and Mental Hygiene. 7 is marked other than "netural", or items 23s or 28s-f ahow traumetic event, the Medical Examine must be notified at To Be Completed by Funeral Director			19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Add															
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item 27 other tr	-	Freda J.		lle		232 Swanton Road, Swanton, Maryland 21561 20b. Pleca of Disposition (Neme of Dete 20c. Location - City or Town, Ste												
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ury ury		4 Donetion					Rose	e H	i11	Ceme	tery	12	2/21/99	wanton, MD)		
Important: If if any injury or once.		21. Signature of F	uneral Service	e Lican	Pee 1		22. Nama and Address of Facility Stewart Funeral Home											
	4	131	calley 1	Y _ X	sucosci								Oaklan		D 2:	1550		
sician		23a. Part1. Enter shock, or her	tha disease, o ert failure. Lie	or comp et only	plications that ca one ceuse on ee	used the c ch line.	death. Do not	t enter	the mod	de of dyir	ng, such es	s cardiac	or respiratory	errest,			Approxim Intervet I Onset er	
edical		tmmediate Cause	(Final		Α	1	·										_	
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ched	l XS	Pert II. Other signi			ontributing to dee	th but not	resulting in th	he und	erlying o	ause giv	en in Part	i.					to the caus	
d by	5	Cholel	ithias	ıs									10	Yes	2 № No	3 Pr	obably 4	

25. Wes case referred to medical

29b. Signature and the of certifier

Dr. Paul Snow, MD

3 Suicida

29a. Certifier (Check only one)

4 Homicide

6 Could not be determined

2 Medical Examiner:

3 Probably 4 Unknown 1 ☐ Yes 2 No

23b. Did tobecco use contribute to the cause of death?

24e. Wes en eutopsy performed? 1 ☐ Yes 2 X No 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1 ☐ Yes 2 ☐ No

Hospitet: 1 X Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28c. Injury et Work? 28e. Dete of Injury (Month, Dey Yeer) 28b. Time of 5 Pending investigation 1 Naturai injury 2 Accident

12/18/99

1 Yes 2 No

D09157

28d. Dascribe how injury occurred

28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) Hospital

PM

pt aspirated gastic contents 28t. Location (Street and Number or Rural Route Number, City or Town, State) Sac Hrt Hospital Cumb Md

12/23/99

29d. Data signed (Month, Dey, Yeer)

Certifying Phyeicien: To the best of my knowledge, deeth occurred et the time, date end pleca, end dua to tha cause(s) and manner es steted.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

26. Piece of Deeth (Check only one)

30. Name and address of parson who completed cause of deeth (Item 23a) (Type, Print)

124 West Third St., Cumberland, Maryland

31. Date filed (Month, Dey, Year) State Registrar

10

32. Registrer's Signeture **DEC 27**



29c. Licanse number

Division of Vital Records,

Hospital or Attending Physician: The law requires that the death certif

ed by the ettending detached for use

pege 2

After

within 24 hours efter death.

To the Funerel Director: A completely filled in by the fi

To the

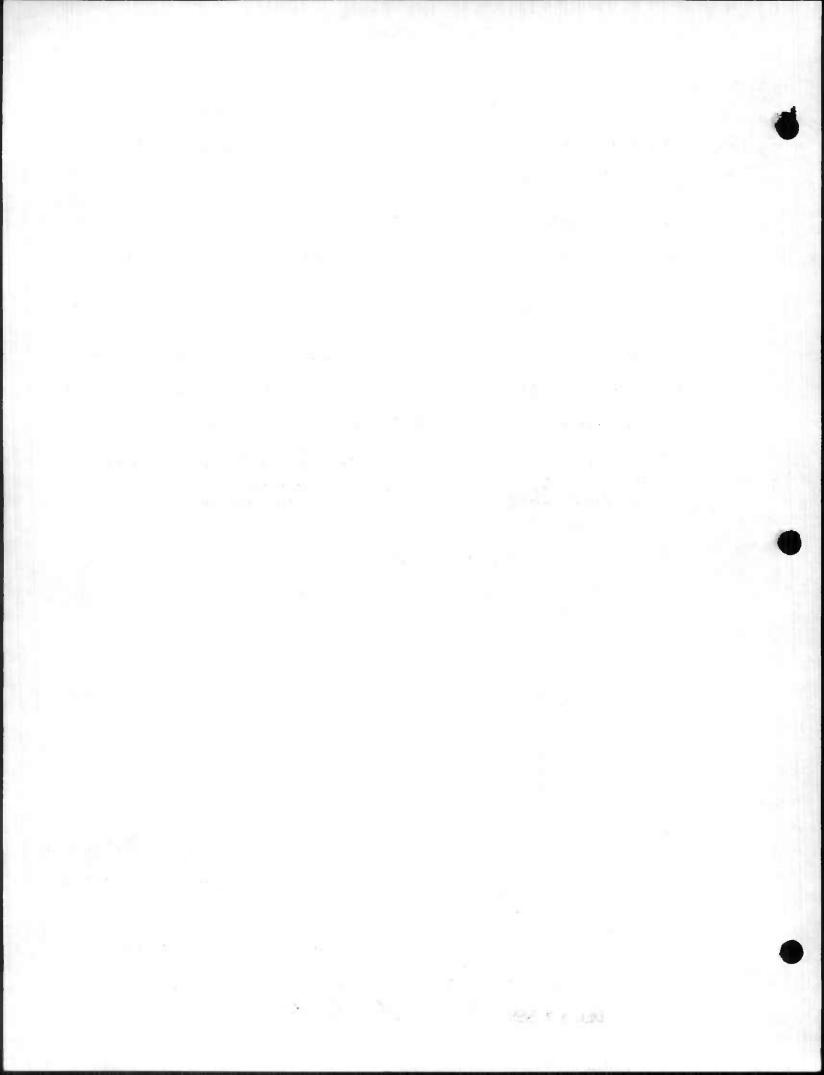
by

Completed

Be

Certification: To

Medicai



Division of Vital Records, P.O. Box 68760,

					24a. Was an autopsy performed?	24b. Were autopsy tindings available prior to completion of cause of death?				
25. Was case reterred to medical				26. Place of I	Death (Check only one)					
examiner?	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 KResidence 6 Other (Specify)									
7. Manner ot Death 1 N Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	м	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred					
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special		t, tacto	281. Location (Street and Number or Rural Route Number, City or Town, State)						

29b. Signature

WCKE 491 M

and title of cortifier

O.C.M.E.

29c. License number

29d. Date signed (Month, Day, Year) December 23, 1999

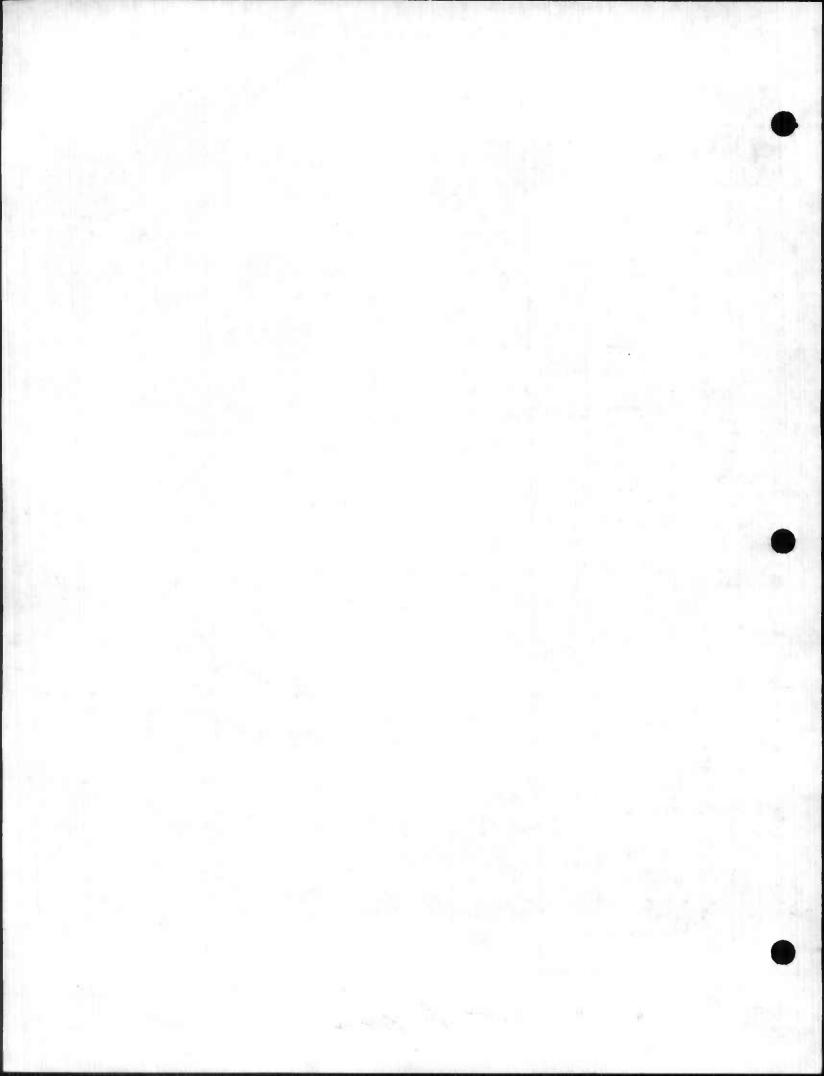
nd address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date tiled (Month, Day, Year) State Registrar

82. Registrar's Signature

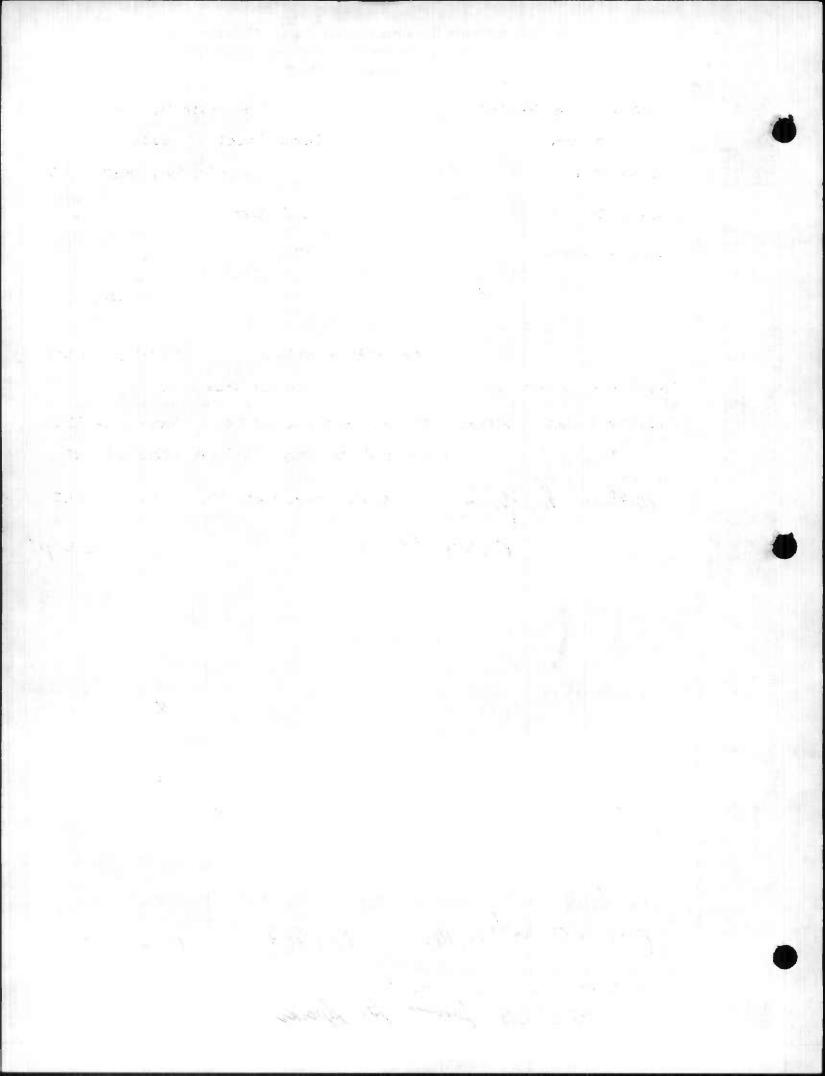
the Hospital • Funeral within 2 To the



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State of Maryland / Department of Health and Mental Hygiene 99 4 1952

			Certificate of Death	Reg. No.	
		Decadent's Neme (First, Middle, Last)		2. Date of Deeth Month Dev Yeer	3. Time of Death
	Physician /Medical	Carroll Ann MAUNDER		December 22, 1999	9 11:20 am
	Examiner	4a Facility Neme (If not institution, give street end number)	4b. City, Town, or Lo	ocation of Death 4c. County of Deat	h
7		4008 5th Street	North Be	each Calver	t
	Funeral Director	5. Social Security Number 577 54 2821 Usual Rasidence of Decedent 6. Sex 1	Yrs. H Under 1 Year If Under 24 Hrs. Months Deys Hours Min.	(Month, Day, Year) Co	hplace (Stete or Foreign buntry) h., D.C.
	Meryland -f ahow find at		wn or Location North Bea	ach	10d. Inside City Limits 1X Yes 2 □ No
	3a or 28a-f a	10e. Street and Number 4008 5th Street	101. Zip Code 20714	10g. Citizen of Whet Co USA	ountry?
21215-0020	be filed within 72 hours efter death with the Meryland nat Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Express must be notified at event, the Medical Express must be notified at Be Completed by Funeral Director	11. Maritel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No It Yes, Give Yeer or Detes:	13. Wes Decedent of Hispenic Origin? (Spif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- D Rican, etc.) 14. Race - Ame Bleck, White Specify: W	e, etc.
2-0	ed within 72 ho ygjene. Ner then "neturi nt, I're Medical Completed	15. Decedent's Education (Specify only highest grade completed)	e. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	16b. Kind of Business/	Industry
121	within then then then then then then then the	Elamantary/Secondary (0-12) Collage (1-4or 5+)		federal go	vornmont
	Hygie ther the Co	17. Fether's Neme (First, Middle, Last)		a (First, Middle, Maiden Sumeme)	veriment
Maryland	Saby W		Beatrice	e Rosalie Harvey	
ary	should Manual Ma	19e. Informent's Neme/Reletionship (Type, Print)	b. Mailing Addrass (Street and Number or Run	ral Route Number, City or Town, Stete, 2	Zip Code)
_	s 1 end 2 should f Health end Mer frem 27 is marke other traumatic)11 Farrington Ct., #		~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~
	Pege nent o int: If	cemet	of Disposition (Name of ery, cremetory or other place) politan Crematory 1	Dete 20c. Location - City or 2–23–99 Alexandri	
Balt	permit. Peges Department of Important: If it any injury or o	21. Signeture of Funerel Service Licensee	22. Name end Address of Fecility Rausch Funeral Home	e. P.A. Owings.	MD 20736
	Physician /Medical Examiner	disease or condition resulting in deeth)	onot enter the mode of dylng, such as cardiac	or respiretory errest,	Approximate Interval Between Onset and Death
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Divi	tal or At its after al Direct led in by	4 ☐ Homicide determined 28e. Plece of Injury - At home, building, atc. (Specify)	tarm, street, tectory, office	28t. Location (Street end Number or Ri City or Town, State)	urar Adule Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completaly filled in by the funeral Director of the Medical Certification	29e. Certifier (Check only one) 10. Certifying Physician: To the best of my knowledge on the basis of examination early and megner stated.		rred et tha tima, date end plece, end dua	a to the causa(s)
	Within Com	29b. Signature and title of certified. Si 'Ver, W	D2/46 }	29d. Date signed (Mont	in, Day, Year)
	15	30. Neme and address of person who complated cause of deeth (Item 23a Bruce Silver, M.D., Prince Fre	1	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
	State	31. Dete tiled (Month, Day, Year) 32. Registrer's Signeture	1		
	Registrar	DEC 2 7 1999 ▶ Benev	B. Sparks		



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEMS: #7,17,18 PER INFORMANT G781 3-8-2000 WR Certificate of Death 1. Decedent's Nama (First, Middle, Last) 3. Tima of Death 2. Date of Death Month Day **Physician** William T. NELSON 19, 1999 Dec. 10:15 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Cuppett-Weeks Nursing Home 0akland Birthplace (State or Foreign Country) If Under 1 Yaar If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 6. Sax 8. Date of Birth (Month, Dey, Year) **Funeral** Days Hours Min. 10XM 2□ F Months Yrs. Director 78 188-18-0498 68 Mar. 6, 1921 Pennsylvania Usual Residence of Deceden death with the Maryland 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits Mode 7 is marked other than "naturel", or frems 23s or 28s-f show traumstic event, the Modical Examinar must be notified as 1 ☐ Yes 2 ☑ No Director MD Oakland Garrett 10e. Street and Number 101. Zip Code 10g. Citizen of What Country? 21550 1127 Sand Flat Road USA Funeral permit. Pagas 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important if flem 27 is marked other than any Injury or other trauments. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give 7.π./ ↑ ↑ Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status 1 Naver Married 2 Married 1 Yes 2 No Specify: Specify: White WWII þ 3 Nidowed 4 Divorcad Yaar or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12th Laborer Natural Gas Company 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumama)
MARGARET PEARL ASHBY TALBERT WILLIAM NELSON Albert Nelson P Marlant 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Greg Nelson/Son 1127 Sand Flat Road, Oakland, Maryland 21550 20b. Place of Disposition (Neme of cemetary, crametory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, Stata Date 1 Burial 2 Cremation 3 Removal from State 12/23/99 Greene Co. Mem. Park Waynesburg, Pa. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servica License Stewart Funeral Home 23a. Part1. Enter the disease, ir complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervat Between Onset and Death Physician /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Examiner physician and the burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequanca of): that the death cartificate be execu Box 68760, Physician/Medical Due to (or as a consequenca of): 88 usa been signed by the e should be dateched f Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? P.0 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was an autopsy performed? hes paga 2 2 ANO 1 ☐ Yes 1 Tyes 2 No certificata Division of Vital or Attending Physician: eftar death. Director: Aftar this certifica director, 25. Wes case referred to medical examinar? Be 26. Placa of Death (Check only one) examinar? Other: 4 Nursing Home 5 Residence 6 Other (Specify) o F 1 | Inpatient 2 | ER/Outpatient 3 | DOA funaral 27. Manner of Deeth Date of Injury (Month, Dey Yaar) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida Location (Street and Number or Rural Route Number, City or Town, Steta) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide A 24 hour. The Funeral D Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the cause(s) and manner as stated.

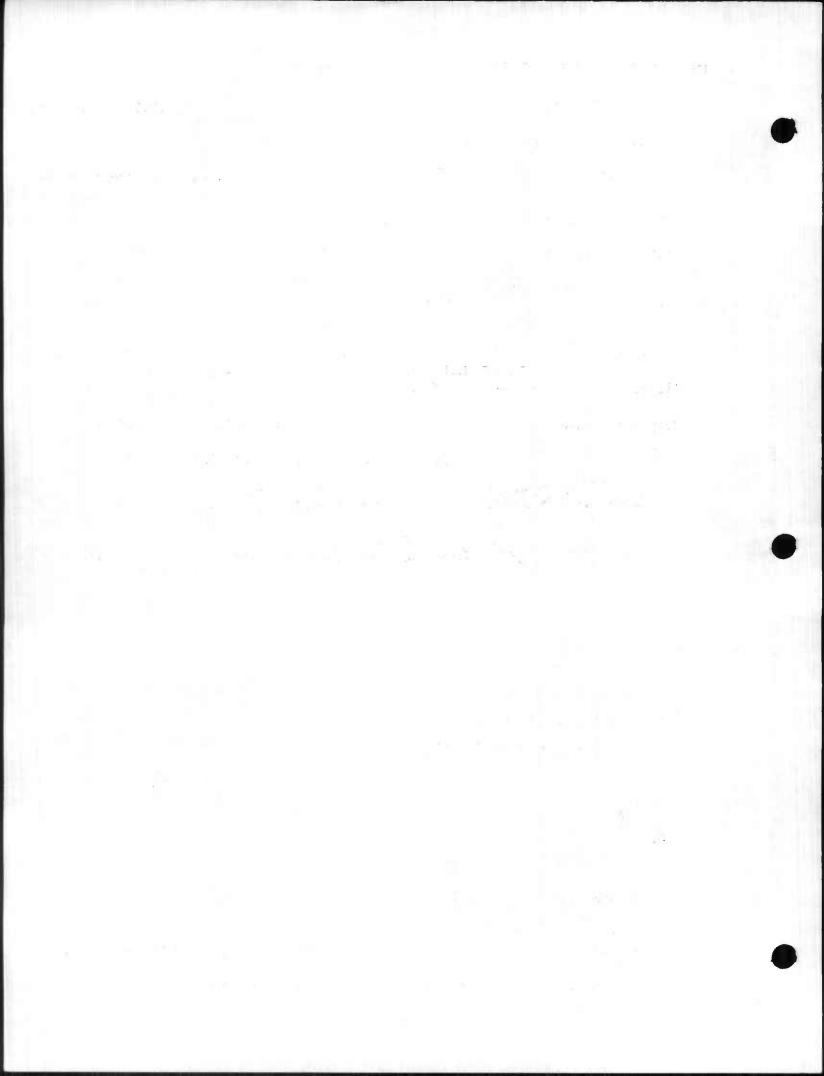
| Medicaf Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) Medical 29a. Certifier complataly and manner stated. To the I 29d. Data signed (Month, Day, Year) 290. Signature and title of certifier 29c. License number D26568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Roger A. Lewis, MD 603-B W. State St., Terra Alta, WV 26764

State Registrar 31. Date filed (Month, Day, Year)

DEC 22

1999

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year WILLIAM NAUGHTON DECEMBER 27,1999 12:37pm 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Frederick Calvert Calvert Memorial Hospital | Wonder 1 Year | Months | Days | Hours | Min. | Wonth, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 1€M 2□ F 66 April 4 1933 WashingtonDC 577 42 2591 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Huntingtown Maryland Calvert 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20639 2921 Deep Landing Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Merried SpecifyWhite 1 Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) Am Track 12 Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Mary Pace John Thomas Naughton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20639 2921 Deep Landing Rd. Huntingtown, MD Shirley J. Naughton- wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Othar (Specify) Dunkirk Maryland Southern Memorial Gardens 21. Signature of June el Service Licensee 22. Name end Address of Facility Rausch Funeral Home PA 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, auch as shock, or haart failure. List only one cause on each line. Rd. Port Republic MD 20676 or raspiratory arrest, Approximata Approximata Interval Between Onset and Death cardiogenic Immedieta Cause (Final Montes disease or condition rasulting in daath) Wears. Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Hypertension 24b. Wera autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only ona)

Attanding Physician:

Affer

death.

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To the I

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Box 68760.

P.O.

Records,

Division of Vital

Physician

/Medical

Examiner

Director

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Hygiene.

Pages 1 and 2 should be I nent of Health and Mental I int: If Item 27 is marked of

Department of Health a Important: If Nem 27 Is any injury or other tra

Physician

Examine

/Medical

filed within 72 hours after

Baltimore, Maryland 21215-0020

Completed by Physician/Medical Be edical Certification: To Director: / 24 hours after die Funeral Direct

Pulmonary Asbestosis 25. Was case raferred to medical examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yas 2 ☐ No 2 Accident Investigation 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

4 Homicida

29a. Certifian

🄁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to tha cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier P. Sterner MD

7245

29d. Date signed (Month, Day, Year) December 28

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

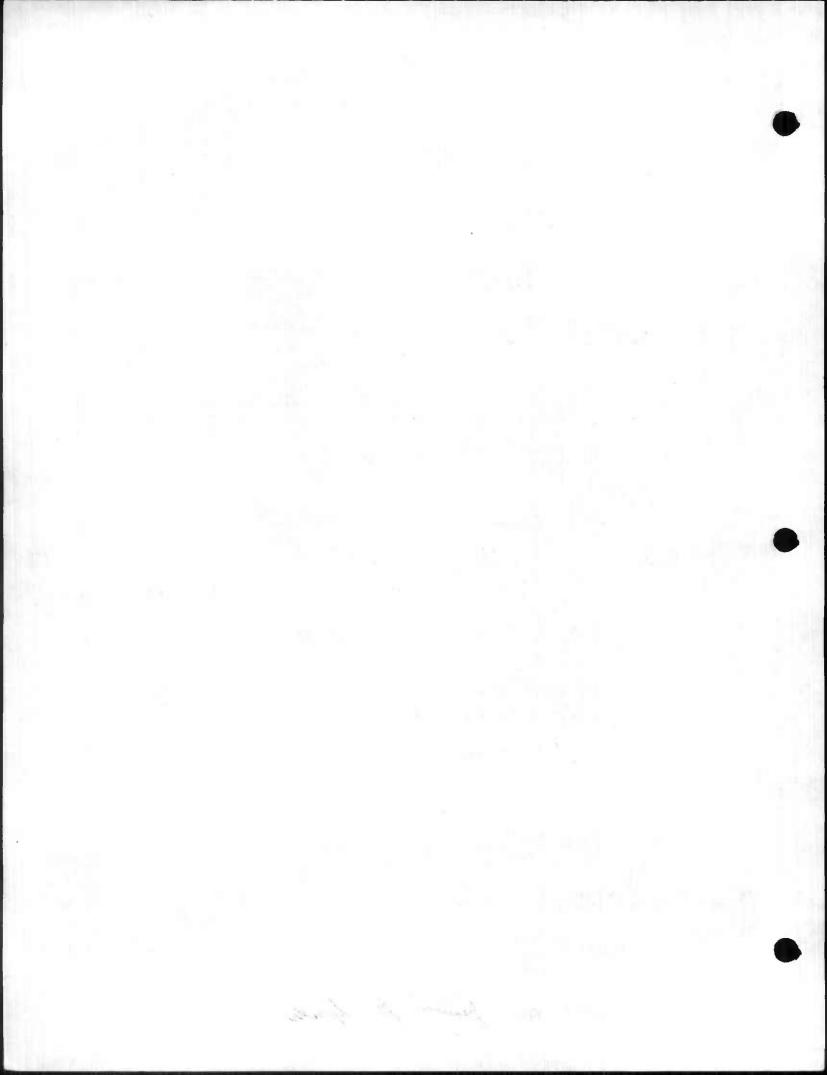
GERALD STERNER, MD, 31. Date filed (Month, Day, Year)

DEC 29

OWINGS 32. Registrar's Signature

MD 20736

State Registrar

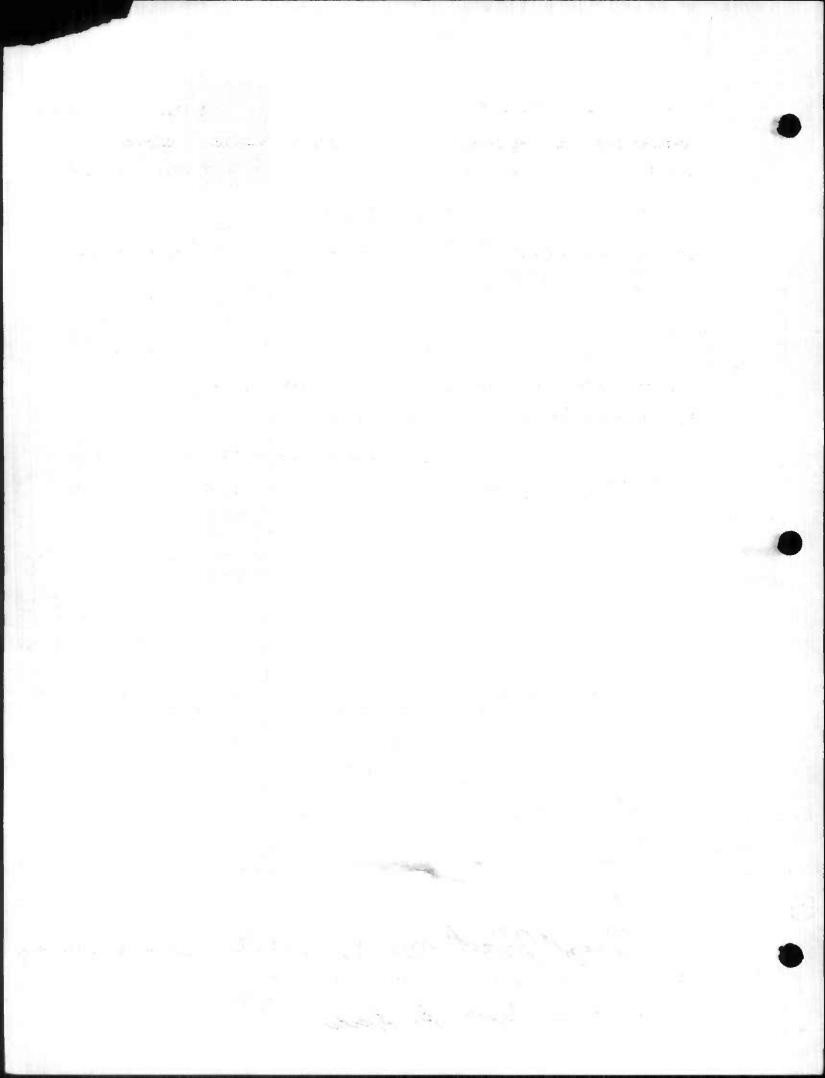


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State of Maryland / Department of Health and Mental Hygiene

					Certif	ficate of	Death		Reg. No.	1 4	1955
Dhusisi		1. Decedent's Nama (First, Middla, La	ast)					2. Data of D		Yaer	3. Time of Death
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Examin		4e. Facility Nama (If not institution, gi	ve street end number	7)			4b. City, Town	or Location of Dee	h 4c. County	of Death	
يدلون		Calvert County N						Frederick	Cal	vert	
Funeral Director		218 18 5463	Sax 7. A	age (In yrs. lest b		Under 1 Year onths Days	Hours I	Min. June	7 1 9 1 6	9. Birthp Mary	lace (State or Forai
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tha 28a	Director	10e. Street and Number		1	1	10f. Zip Coda			10g. Citizen of	What Cour	itry?
ath with		8720 Broomes I				20615			United	a Sta	tes
n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Nevar Married 2 □ Merried 3 ☒ Widowed 4 □ Divorced	12. Was Decedan Armed Forces 1 ☐ Yas 2 ☑ If Yes, Give Yeer or Datas	No		Decedant of I s, specify Cub Yes 2120 No	? (Specify Yas or N uart <i>o</i> Rican, atc.)	14. Race - American Indien, Bleck, Whita, atc. Specifyhite			
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ysician: The law s cartificata has director, page 2	E O							10	Yas 2 NO	10	Yas 2□ No
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s aftar daath	Certification:	4 Homicide datamined	286. Place of II	njury - At homa, itc. (Specify)	farm, streat,	factory, office		281. Location City or To	(Street and Numi wn, State)	ber or Rura	il Houta Number,
to use hospina or Attendary Fra within 24 hours after deathin. To the Funeral Directors After thi completely filled in by the funeral	edicai (29a. Certifier (Check only one) Certifying Pl	nyalcian: To the besi miner: On the basis and mannar s	of examination a	ga, daath occ and/or invasti	curred at the ti igation, in my o	me, date and p opinion, daath o	lace, and due to the occurred at tha tima	cause(s) and madata and place,	annar as st and due to	tated. tha cause(s)
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		J. John Barth	M.D. Pr	rince F	rede:	rick N	1d 206	76			
Sta Registra		31. Date filed (Month, Day, Year) DEC 2 7 199		trar's Signatura	6.	back	,				

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3 Time of Death Month 12 **Physician** 28 1999 William M. Briggs 6:30pm /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Casey House, 6001 Muncaster Mill Rd. Rockville Montgomery if Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Dete of Birth Birthplece (State or Foreign Country) **Funeral** Deys Months Hours 1**™** M 2□ F Director 12/26/1912 579121546 87 Kansas Usual Residence of Decedent the Marylend 10a. State 10b. County 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits MD Montgomery Bethesda 1 X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? permit. Pages 1 and 2 should be filed within 72 hours after death with I Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or important: If Item 27 is marked other than "natural", or items 23s or any Injury or other traumatic event, the Medical Examine must be none. 6103 Massachusetts Avenue 20816 USA Funeral 11 Marital Stetus Was Dacadent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married 1 X Yas 2 □ No If Yes. Give Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Spacify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 5+ Military Law Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 2 Fred C. Briggs Sara Klose 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Straat and Number or Rurel Route Number, City or Town, Stete, Zip Code) 20 Sunset Dr., Alexandria, VA 22301 William M. Briggs, Jr./son 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 A Cremation 3 ☐ Removel from State 01/10/00 National Crematory Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Joseph Gawlers Sons 21. Signature of Funaral Sarvica Libersee 5130 Wisc. Ave, NW, Washington, DC 20016 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical 10 Days Urosepsis Examiner Dua to (or as a consequence of): Physician/Medical Examiner The law requires that the death certificate be executed the buriel-transit Sequentielly list conditions, if eny, leading to immediate causa. Entar Underlying Ceuse (Disease or Injury Due to (or as e consequence of) P.O. Box 68760. that initiated events Due to (or es a consequença of) resulting in daeth) Lest USB BS Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 9 signed by 1 Yes 2 No 3 Probably 4 Unknown Congestive Heart Failure Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy performed? Completed Anemia (undetermined etiology) has page 2 1 □ Ves 218 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Placa of Death (Check only ona) Hospitel: 1 ☐ tnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 HOther (Specify) Hospice Certification: To 1 Tyes 2 X No After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 X Natural deeth. 1 Yes 2 No 2 Accident 24 hours efter deet Funeral Director: 6 Could not be datermined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Sulcide 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) filled in by 4 Homlcide Hospital edicai 29a. Cartifier 1 Certifying Phyeician: To the best of my knowledge, death occurred at the time, deta end placa, end due to the ceusa(s) and menner as stated. completely (Check only 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, end due to the causa(s) and manner stated. one) within 2 To the I \$ 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12/29/1999 D0037620 30. Name and addrass of person who complated cause of deeth (Itam 23a) (Type, Print) Mark Godec, MD, 6001 Muncaster Mill Rd, Rockville, MD 31. Date filed (Month, Dey, Yeer) 32. Registrar's Signature State 1020 back JAN Registrar

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Registrar

State

Baldanza

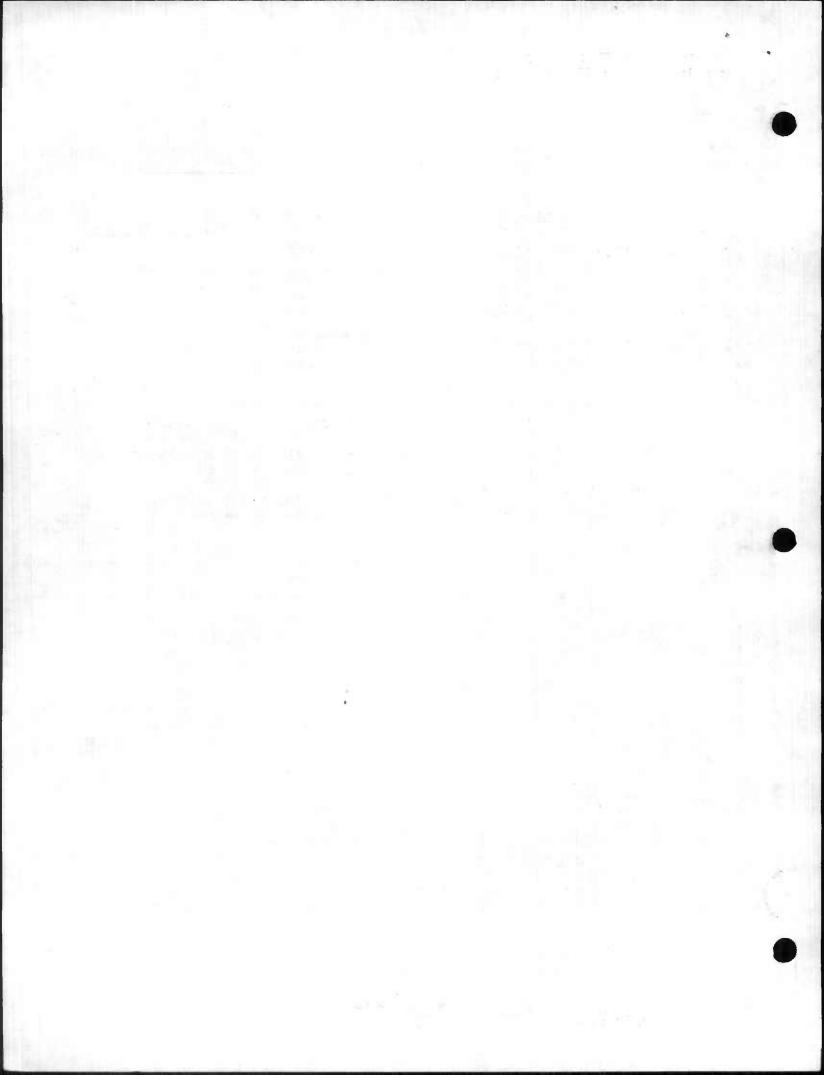
32. Registrar's Signature

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31. Date filed (Month, Day, Yeer)

10753 Falls road Sute 225 Litheralle, Maryland



Box 68760, Division of Vital Records,

Examiner attending physician and for use as the burial-transit The law requires that the death certificate be asscuted been signed by the s should be detached certificate or Attanding Physician: director. Medical Certification: To this After death. hours after death, uneral Diractor: A ily filled in by the fi

Physician/Medical

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29e. Certifier

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Physician

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Funeral

Director

r than "natural", or items 23s or 28s-f show the Wedical Examiner must be nothled at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene.

By Injury or other traumatic avent, the Health British once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

by

Completed

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To the Hospital of within 24 hours at To the Funeral Discompletely filled it



5530 Wisconsin Ave. #1045, Chevy Chase, MD 20815 Ellen Pinholt MD., 32. Registrer's Signeture

Inhort MD

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

1 🔀 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner steled.

29c. License number

D51015

29d. Date signed (Month, Day, Year)

January 5, 2000

Janes 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#23a perPhyG779 1/10/2000 EW 1. Decedant's Nama (First, Middla, Last) 2. Data of Death **Physician** 23 Leroy Lurant /Medical 4a Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Aga (In yrs. last birthday) If Under HOSP Hmore If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplaca (Stata or Foreign Country)
Battirocc 5. Social Security Number If Under 1 Year **Funeral** Months Hours 213-62-4288 18 M 2□ F Yrs. Director Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No BALTIMORE Directo MARYLAND 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? 209 N. FULTON AVE., IST FLOOR b U.S.A. 21223 12. Was Decadent Evar in U,S. Armed Forcas? 1 BYyas 2 □ No If Yas, Giva Yaar or Datas: ∠NKNOWN 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 1 Navar Marriad 2 Married 8 21215-0020 1 Yes 2 No Specify: Specify: BLACK à 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) Alameda EXXON 12TH GRADE MECHANIC Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Be 8 Montal DURANT DOROTHY McDowell 1001 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) DOROTHY DURANT (MOTHER) 209 N. FULTON AVENUE, APTIMICA, BALTO, MD 21283 Baltimore, 20a. Mathod of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burlal 2 Cramation 3 ☐ Removal from Stata Department Important: II any Injury o once. 12-29-99 BALTIMORE, MARYLAND METRO CREMATORY 4 Donation 5 Othar (Specify) 22. Nama and Address of Facility 21. Signature of Fusional Service License JOSEPH H. BROWN JR. FUNERAL HOME DI40 N. FULTON AVENUE, BALTIMORE, MD QIQIT 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death ARRYTHMEA **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in deeth) Examinel ATRIAL FIBRILATION Examiner Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Cause (Disaase or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): and 99 edical Dua to (or as a consequence of): the **Physician/M** Box 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o PLACEMENT PACEMAKER 1 Yes 3 Probably 4 Unknown Records, ò HEMODIALYSIS FOR ENGSTAGE 24b. Ware eutopsy tindings available prior to 24a. Was an autopsy Completed completion of cause of death? 200 No 1 Yas of Vital 25. Was casa rafarred to medical axaminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yas 2 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Data of Injury 28h Time of 5 Pending invastigation Division Attending 1 Matural 2 Accident death. 1 V65 Director: / 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or, Teleg., State) 3 ☐ Suicida 28a. Placa of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 ☐ Homicide

State Registrar 29a. Certiflar (Check only one)

29b. Signature and title of cert

22. Registrer's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

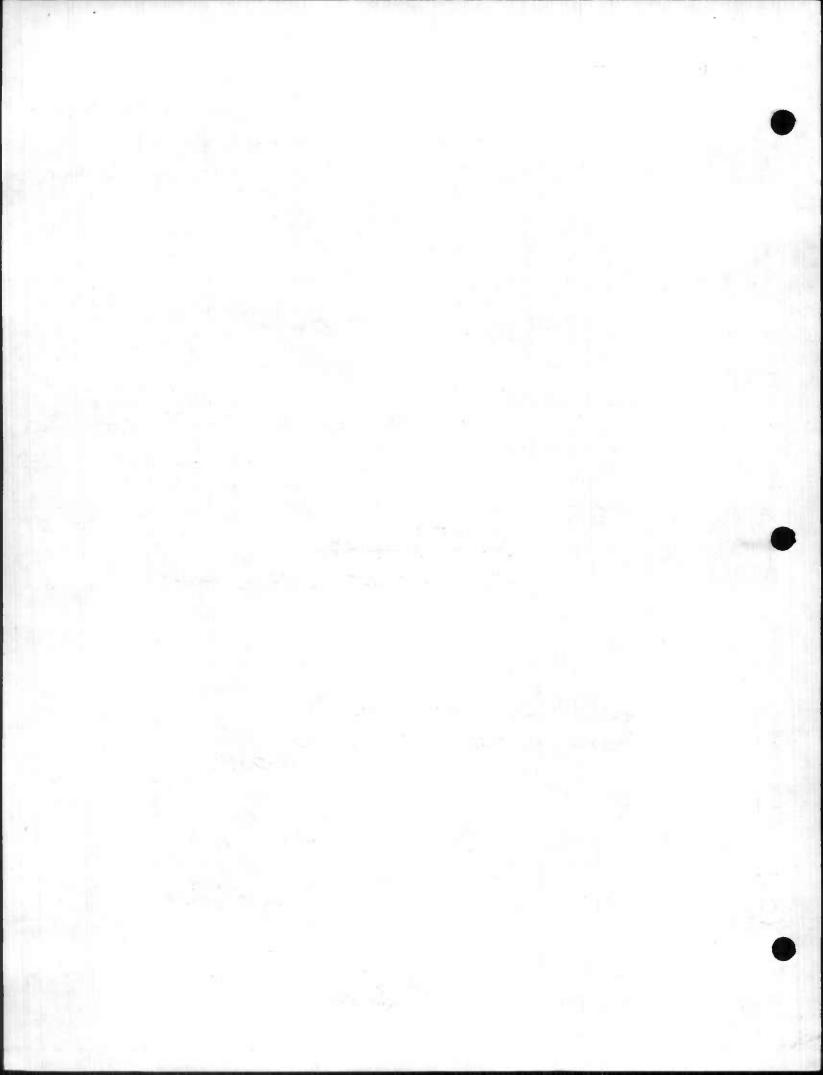
Medical Examiner: On the basis of axaminetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated.

29c. License number

0-17522

who completed cause of deeth (Item 23a) (Type, Rrint) PVTAL N3W143 Z2 S. GKEENE ST. BALTIMORE, MD, 21201

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 AMEND ITEM: #7 PER F.H G779 1-21-2000 WR. Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Day 1999
DECEMBER 21, 1999 1:50 PM IRENE W. 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death SILVER SPRING MONTGOMERY ASSISTED LIVING BEDFORD COURT If Under 1 Ye If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 1 - 25 - 05 9. Birthplace (State or Foreign (Month, Dev. Year) Days 1□M 2₩F Months 94 5-1925 BOSTON, 021-03-7600 Usual Residenca of Deceden 10a, Stata 10c. City. Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No SILVER SPRING MD. MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3700 International Drive U.S.A. 20906 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ Ø No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Raca - American Indian, Black, Whita, atc. 1X Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) EDUCATION **EDUCATOR** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) MARY T. CAREY FRANK F. ENO 19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 11410 Strand Drive #310 Rockville, MD. 20852 Sarah Jenkins (Executor) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) 1/12/00 Falls Church, VA. National Crematory 21. Signature of Funeral Service Lices 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, DC. 20016 23a/Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) a CONGESTIVE HEART FAILURE Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23h. Did tobacco use contributs to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show stical Exactions must be notified at

Peges 1 end 2 should be filed within 72 hours effer in ent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or ite

of Health a Heam 27 Is r other tra

Department of Important: If it any injury or o

Baltimore, Maryland 21215-0020

Box 68760

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Division of Vital

The law requires thet Records.

Physician:

or Attending

Director

Funeral

þ

Completed

Be

the Maryland

the death certificate be executed

Examiner ician and burial-transit physician s the burial Physician/Medical 88 080 þ Completed page 2 s certificate has Certification: To Be this funeral After s sfter death. 6

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of tnjury 28c. Injury at Work? 28d. Describe how injury occurred 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier

(Check only one)

11 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.

B30692

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

DECEMBER 23, 1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GABRIEL BERREBI, MD. 15225 Shady Grove Rd. #305, Rockville, Md. 20850

31. Date filed (Month, Dey, Year) State

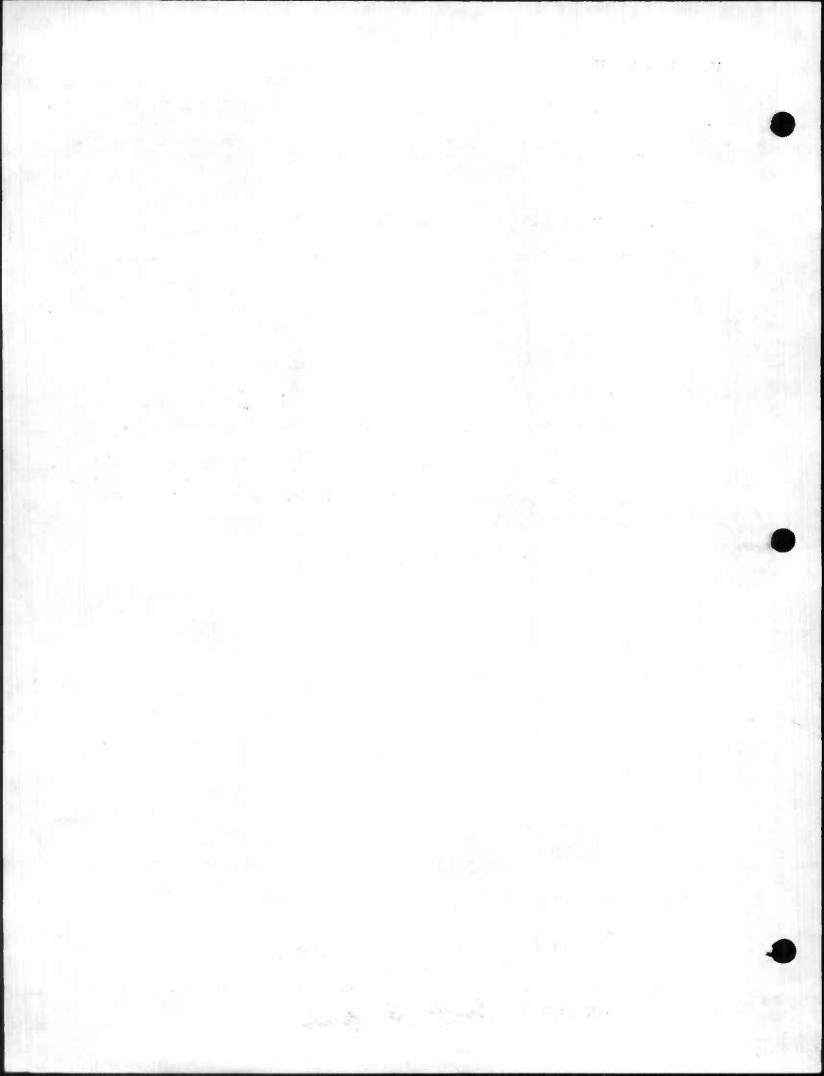
JAN

32. Registar's Signatura

filled in

edical

To the Hospital o within 24 hours of To the Funeral Di completely filled in



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#7 23a&23 PRT. II PER MD. G779 1-7-2000 J.A. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 1999 2. Dete of Death Month **Physician** December /Medical 4a Facility Neme (If not institution, give str and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTI MOLE
If Under 24 Hrs. 8. Date 7. Age (In yrs. last birthday)

Yrs. If Under 1 Year 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 262-72-8318 Director Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahon 1 Yes 2□No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ U.S.A Demit. Peges 1 and 2 ahouid be filed within 72 hours effer deeth with Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23s, any injury or other treumatic event, the Medical Examinar must be pages. 21230 Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 Yes 2 No
K Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Raca - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baitimore, Maryland 21215-0020 WHITE 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) POMESTIC 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 8 UNKNOWN UNKNOWN 19e. Informant's Neme/Reletionship (Type, Proping) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 34 MARKET PLACE BALTIMORE, ND. 21202 DEPT. OF AGING ALEXANDER Dec 23 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other p 20c. Localion - City or Town, Slete 1 Burial 2 Cremetion 3 F 4 Donation 5 Other (Specify) Burial 2 Cremetion 3 Removal from Stete PARMEL CEM. 22. Name end Address of Fecility 21. Signatural Luneral Service Licensee 2829 HUDSON ST 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respirators shock, or heart feiture. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Finel DEMENTIA disease or condition resulting in death) Examiner Examiner CHRONIC RENAL FAILURE physician and the burlai-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings aveilable prior to 24a. Was en autopsy performed? completion of cause of deeth? page 2 s 1□Yes 3 No Division of Vitai 25. Was case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) To the Hospital or within 24 hours after To the Funeral Direction places on places in the 4 Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Dete signed (Month, Day, Year)

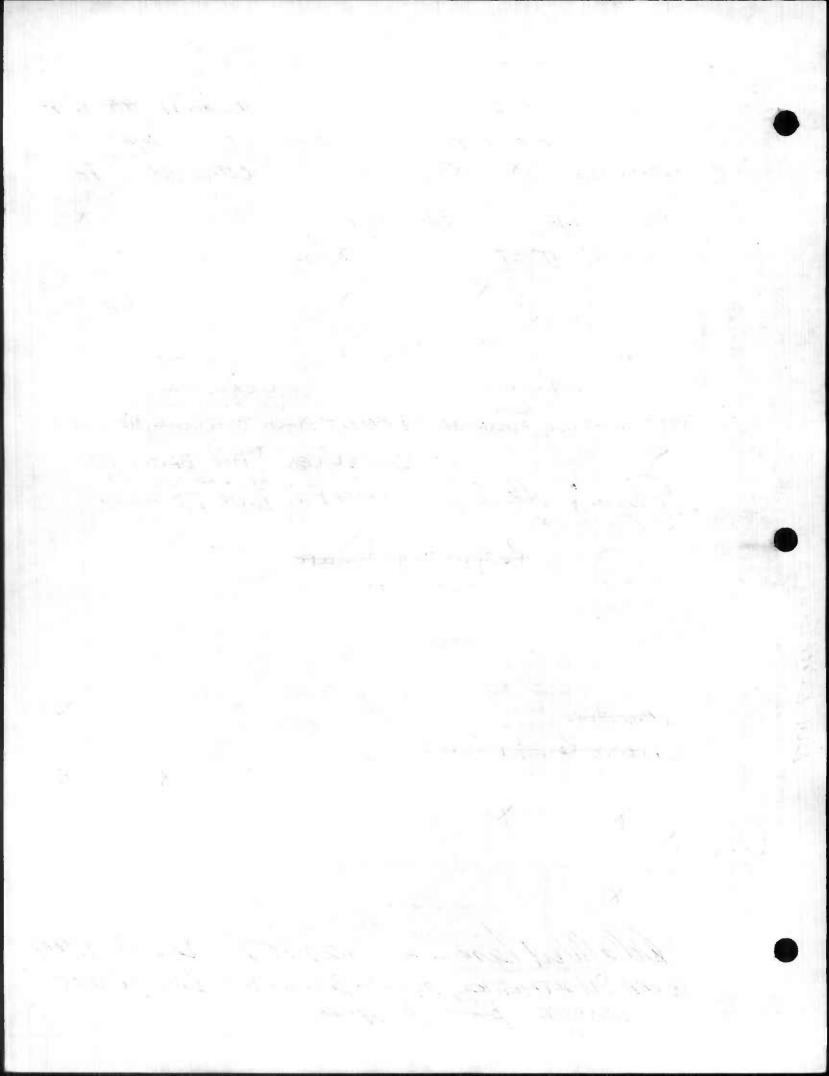
State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

32. Registrar's Signature

Date filed (Month, Day, Year)

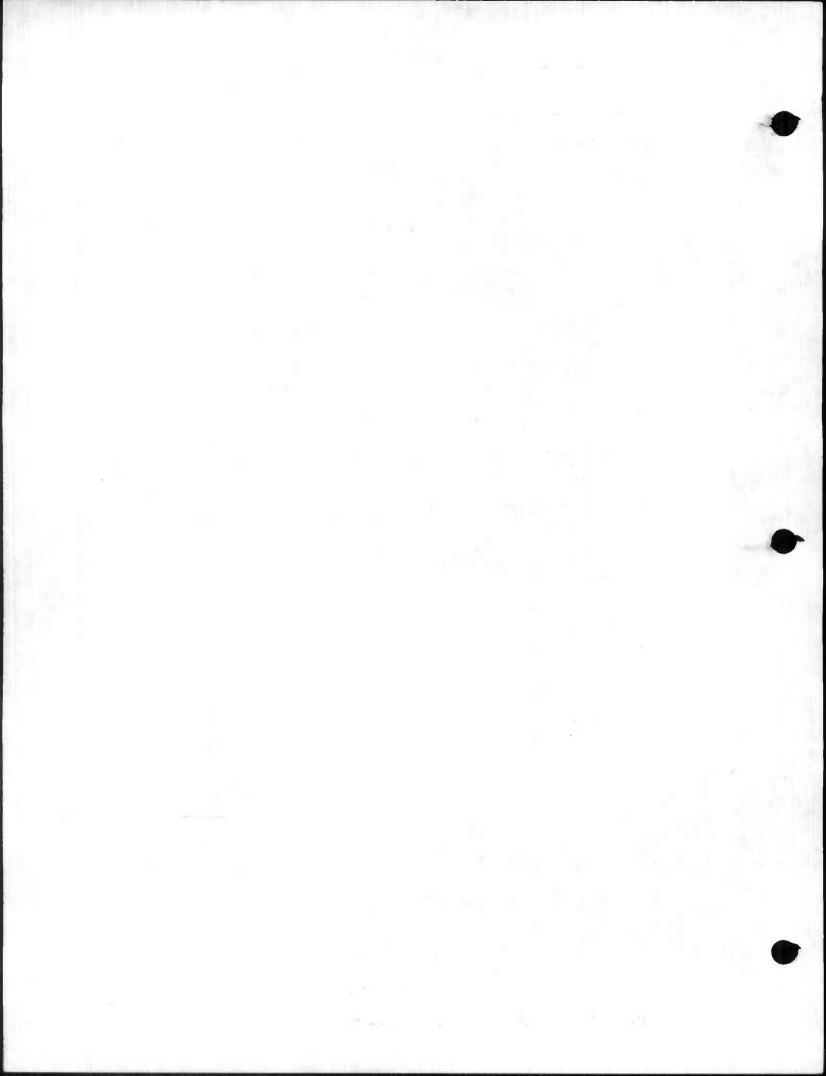
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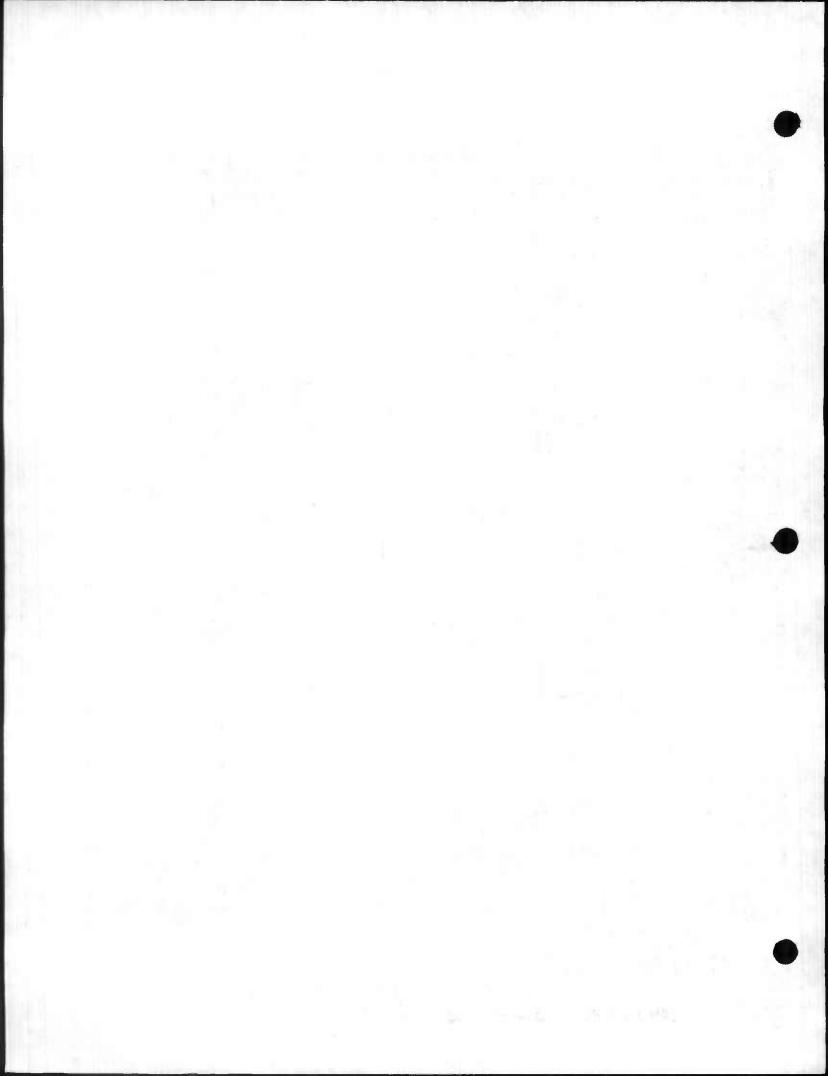
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Α		ertificate of	Death		g. No.			
ian	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Dey Year	3. Time of Death		
cal	Mildred Irene Farley		At City Town and a		30-99	6:55 PM		
ner	4a Facility Name (If not institution, give street end number)			or Location of Death 4c. County of Death				
	3796 CASTLE DRIVE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd	ev) If Under 1 Year	HAMPSTEAL If Under 24 Hrs.	8. Date of Birth		ROLL		
133	234-20-4691 1 M 2MF 80 Yrs	Months Days	Hours Min.	(Month, Dey, AUG. 8,		hplace (Stete or Foreign buntry) T VIRGINIA		
	Usual Residence of Decedent			A00. 0,	1313 1110	VIRGININ		
	10a. Stete 10b. County 10c. City, Town o	Location				10d. Inside City Limits		
ector	MARYLAND N/A BROO	OKLYN				1 ☐ Yes 2 🖺 No		
	10e. Street and Number	10f. Zip Code		10	og. Citizen of What Co	ountry?		
	3822 ST. MARGARET STREET		225		U.S.			
	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No H Yes, Give Yeer or Detes:	1 ☐ Yes 2X No	Hispanic Origin? (Special, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Ame Black, Whit Specify: W			
	15. Decedent's Education 16a. De	ecedent's Usual Occu	pation	1	16b. Kind of Business	/Industry		
-	Elementary/Secondary (0-12) College (1-4or 5+)		during most of worki					
		SEMBLY PER			DEFENSE IN	DUSTRY		
	17. Father's Neme (First, Middle, Last) JOHN H. CAVES		18. Mother's Name	(First, Middle, M		ARTIN		
		allian Address (Or		I Dough M				
			t end Number or Rure DRIVE, HAN			21074		
	20a. Method of Disposition 20b. Place of D	sposition (Neme of			20c. Location - City or			
	W Burial 2 ☐ Cremetion 3 ☐ Removel from Stete	cremetory or other ple AVEN MEMOR	TAT DADIE	JAN. 5,				
	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		ess of Facility SIN		GLEN BURNI			
	1 / W		VENUE, S.V					
	23e. Pert1. Enter the disease, or complications that caused the deeth. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Finel disease or condition resulting in death) a. Pulmonary En		ing, such as cardiac c	or respiratory erre	est,	Approximate Interval Between Onset and Death		
ner	Due to (or as a con	sequence of):						
CARIIIIE	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.	sequence of):						
	Cause (Disease of Injury that initiated events resulting In death) Last	sequence of):						
	Pert II. Other significant conditions contributing to death but not resulting in the	e underlying cause gi	iven in Pert I.		/	to the cause of death?		
	Hypertension Cardiovascula	r Diseas	ė	1024	2 No 3 P	robably 4 Unknown		
				24a. Was ar		Were autopsy findings available prior to		
				perion	1001	completion of cause of death?		
				1 ☐ Ye	s 20No	1 Yes 2 No		
	25. Was case referred to medical		26. Place of Death	(Check only one	θ)			
	examiner? 1 Yes 2 Tho Hospital: 1 Inpatient 2 ER/Output	etient 3 DOA	ther: 4 Nursing Ho	me 5 Recide	DA DA Other (Spe	UGHTER'S Poilty) RESIDENCE		
	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be	ow injury occurred						
	determined 4 Homloide determined determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, tectory, office		City or Town	reet end Number or R n, Stete)	urer Moute Number,		
	29a. Certifier (Check only one) 1 Certifying Phyelcian: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/or end menner stated.	r investigation, in my	opinion, death occurr					
	29b. Signature and title of certifier DR. DEOGRACIAS V. FA	USTINO, Licen	se number	29	9d. Date signed (Mon	th, Day, Year)		
1	Merge war Com ousing, MB	M.D. 7/7	2901		12/31/8	9		
-	30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)		1 m	1	L		
	4111 Lower Beckleys VIIIe Rd.	Hamps	tead, 1	1D. 21	1074			
9	31. Date filed (Month, Dey, Year) 32. Registrar's Signature	1	,					
ar	(ANL L. H. ZHIIII	100 11						

DHMH 16 Rev 6/95



70	EMEN 3	17				(Certifica	ate of	Death	7		Reg. No.	7	7-	7/7	6
n	1. Decedent's Nar										2. Dete of D Month	Day	2 1	Year	3. Tima o	
ŀ	Frank R. Gardina 4a Facility Name (If not institution, give street and number) 4b. City, Town, or L										Decemi	-	3, 1	999	4:17	P.M.
ı	Union M									altim		40.	N/			
	5. Social Security		6. Sex		7. Age (In yrs	. last birth	day) If Und	der 1 Yeer		r 24 Hrs.	8. Date of B	irth			ace (State	or Foreign
	217-38-9		172	4 2□ F	60	Yr	rs.	s Deys	Hours	IVIII1.	Feb.	11, 1	939	Mary	Tand	
-	Usual Residence	10b. County	y		10c. C	ity, Town	or Location							10	d. Inside C	ity Limits
	Maryland	Balt	imore	9	T	OWSO	n								1 ☐ Yes	2X No
1	10e. Street and No	umber					10f. 2	Zip Code				10g. Citiz	zen of W	hat Count	try?	
204 East Joppa Road, Apartment 1201 21286 U.S.A. 11. Merital Status 12. Wes Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - Amerital Status 15. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuben, Mexican, Puerto Rican, etc.)																
	_	rried 2 Mar	rried	Armed For 1 Yes If Yes, Give Year or Da	ces? 2 🖄 No e	J,S.		cedent of F pecify Cub 2 No	lispanic O en, Mexica Specify		ecify Yes or N Rican, etc.)		Black	White, e	etc.	
1	(504	15. Deceder				16a. D	ecedent's U	sual Occup	ation	st of work	tina	16b. Kii	nd of Bus	siness/Ind	ustry	
	Elementary/Sec	-4or 5+)	'/	velry 1	use retire	d)			To	welr	~7					
-	17. Father's Name	e (First, Middle	, Last)	4		new	ACTTÀ I	TICT			e (First, Middl	1		-4	-	
	Frank F	Ronald (Gardi	na, S	r.				Ger	nevie	eve Hil	1				
	19a. Informant's P Judy L.										al Route Num					
1	20a. Method of Di	-	2 DP0	novel from 6		Place of D	Disposition (A	lame of or other pla	ce)		Date	20c. Lo	cation - (City or To	wn, State	
	1X Burial 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify) Oak Lawn Cemetery 12-17-99 Baltimore,									e, Ma	aryla	nd				
	21. Signature of Funeral Service Licensee 22. Name end Address of Facility 1050 York Road, Ruck Towson Funeral Home, Inc., Towson March 1050 York Road, Ruck Towson Funeral Home, Inc., Towson Funeral Home, Inc.												1200			
Completed by Fillysicialymedical Examiner	Sequentially list of if any, leading to cause. Enter Unc Cause (Disease othat initiated even resulting in death)	immediate derlying or injury ets	6 d		rathor Due to (forati	orasa co	ensequence o	rhage Subc		an-In	ominat	e Vei	n			
	Part II. Other sign	ificant conditi	ions contri	buting to de	ath but not re	sulting in t	the underlyin	g cause gi	ven in Parl	t I.	23b. Die	d tobacco	use con	tribute to	the cause	of death
	Cardiamyopathy									1 Yes 2 No 3 Probably 4 Unkn				Unknov		
										ava	ere autopsy ailable prior inpletion of death?	to				
											10	XYes 2	□No		Yes 2	
1	25. Was case rete	erred to medica	al							ce of Dea	th (Check only					
	1 X Yes 2		Ho		·	,	oatlent 3	DUA		Nursing H	ome 5□Re					
	27. Manner of Dea	5 Pendi		28a. Date of (Month	h, Day Year)		ury P	28c. Inju Wo		ZI No	28d. Describe			10.1	ood v	
	3 Suicide	2 Accident investigation investigation 3 ☐ Suicide 4 ☐ Homicide 12-13-1999 4:302:40 M 1☐ Yes 2 ☒ N 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Hospital								4	28f. Location City or T	(Street an	d Number	er or Ruma Eas	Route Nur	
	29a. Certifier (Check only			r: On the ba	sis of examin	owledge,	death occurre	ed at the ti			Pankway, and due to the red at the time	e cause(s)	and ma	nner as st	Alamol ated.	
-	one) 29b. Signature an	d title of certific	er	and mann	er stated.			29c. Licens	se number	r		29d. Dat	te signed	i (Month, i	Day, Year)	
		0	1 11	1-	4				O.C.N						, 200	0
- 1	30. Name and add	dress of person	who com	pleted cause	e of death (Ite	m 23a) (T	ype, Print)									
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Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#1 PER MD. G779 1-10-2000 J.A. Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** GLENN GRIFFIN 9:38 AL 12 99 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UNIVERSITY MANYCANS BALTMONE BALTIMONE Couren MONICAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sax 7. Age (In yrs. last birthday) Birthplace (Stete or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 F 51 Yrs. 218-44-2387 Director unknown **Usual Residence of Decedent** 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hams 23s or 28s-f show the Medical Examiner must be notified at the Maryla 1 Yes 2X No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 W. 23rd Street Funeral 21218 USA 12. Wes Decedent Ever in U.S.
Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: unknown 11. Marital Statusunknown Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. Department of Health and 2 should be fined within 72 hours after a Copartment of Health and Mental Hygiens
Perportant. If hem 27 is marked other than "nethust", or hen any Injury or other traumatic event, the Medical Examinations 1 Never Merried 2 Merried 1□ Yes 2□No Baltimore, Maryland 21215-0020 Black. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) **UMMS** 22 S. Greene Street Baltimore, MD 21201 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) in state 21. Signature of Funeral Service Licent Ronald S. 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Wade, Director Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, which, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Physician /Medical Immediate Cause (Finel Organ disease or condition resulting in death) MULTI SYSTEM TRIGHTE 3 Days Examiner Due to (or as a consequence of): Examiner CIMPHUSIC sician and burial-transit FAILUNE FULM NANS WEEK that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) physician s the burial Division of Vital Records, P.O. Box 68760, HERANTIS 3 UNINGON an/Medical Due to (or es a consequence of): signed by the ettending I Physici by Completed has certificate Be 2 2 2 Certification:

after death.
Director: After this certific

Pert II. Other significant conditions co	ontributing to death but not re-	sulting in the underlyin	ng ceuse given in Part I.	23b. Did tobacco use co	ontribute to the cause of death? 3 □ Probably 4 ☑ Unknown						
				24a. Wes en eutopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?						
				1□ Yes 2≅ No	1 Yes 2 No						
25. Wes case referred to medical examiner?	26. Place of Deeth (Check only one)										
1 Yes 2 No	Hospital: 1 Inpetient 2	ER/Outpatient 3	ng Home 5 Residence 6 Ott	her (Specify)							
27. Menner of Death 1 Neturat 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occu	rred						
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, ferm, street, fec	28f. Location (Street and Num City or Town, State)	ber or Rural Route Number,							

29c. License number

12538

29d. Date signed (Month, Day, Year)

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State Registrar

Medical pletely

29b. Signature and title of certifie

SINA 31. Dete filled (Month, Day, Year)

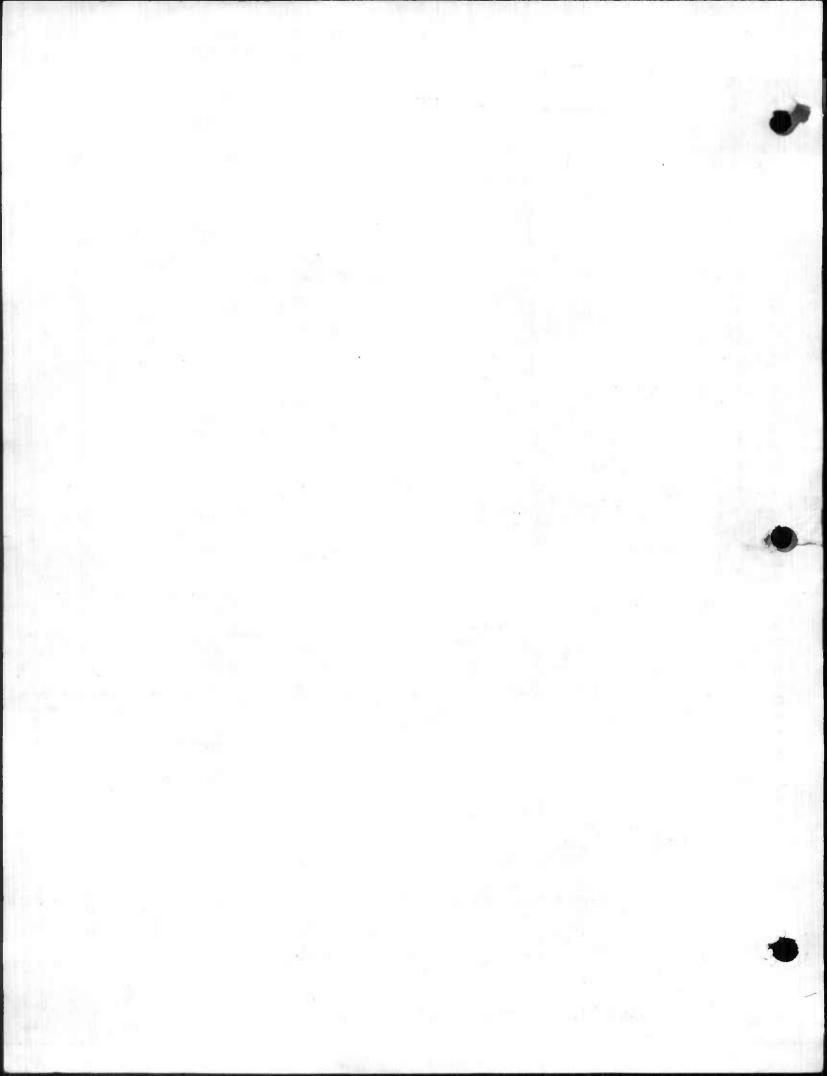
JAN 0 7 2000 Registrar's Signeture

30 Name and address of person who completed cause of death (ttem 23a) (Type, Print)

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MANYCAND

To the Hospital of within 24 hours at To the Funeral D



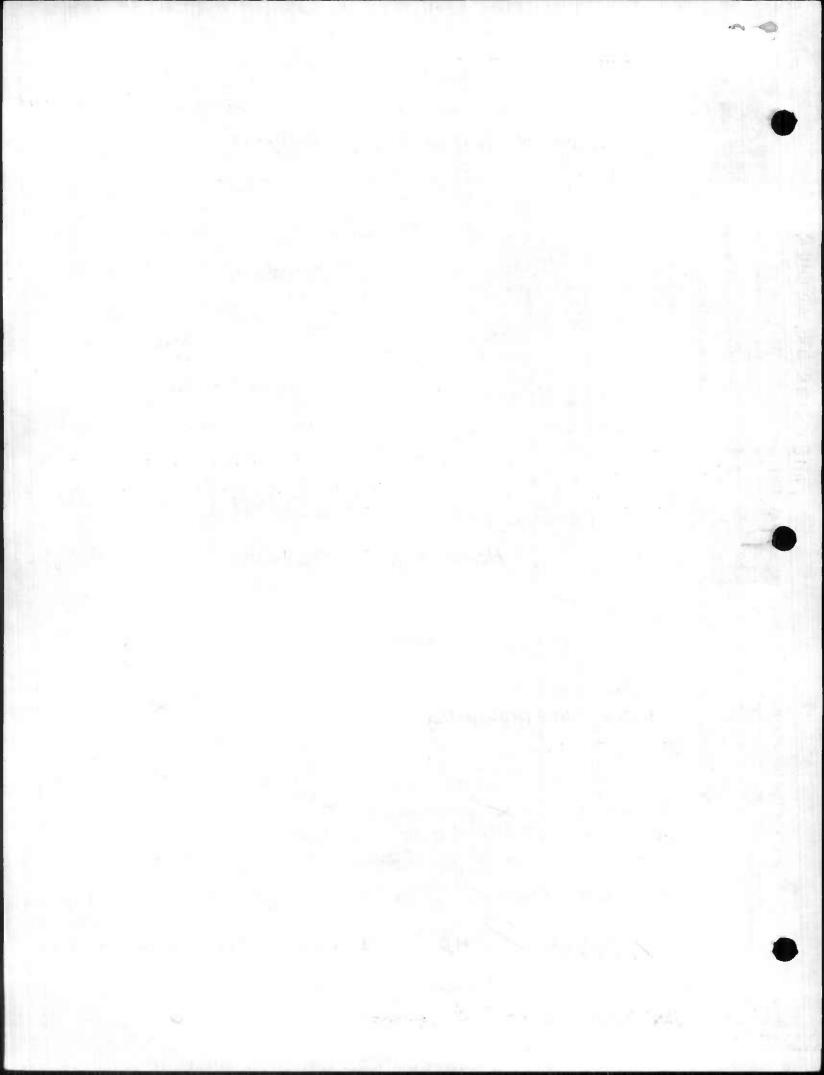
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State of Maryland / Department of Health and Mental Hygiene AMEND#23a&PRT. II & 25 PER MD. G779 1-7-2090.A. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev **Physician** 4:08 P DECEMBER 18, 1999 Hicks Jr. Arthur /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death Examiner Sinai Sinai Itospital

5. Social Security Number | 6. Baltimore Baltimore of If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. lest birthday) Birthplaca (Stete or Foreign Country) **Funeral** Months Deys Hours 1X M 2□ F Director 216-34-7658 05 38 07 M.D 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow Director 1X Yes 2 No Baltimore MD NA 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 6 234 21216 U.S.A. 4019 Duvall Funeral "netural", or items 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No 1 ☐ Yes 2 StNo Specify: Specify: Py 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within Elementery/Secondery (0-12) College (1-4or 5+) Baltimore City 12th grade

17. Father's Neme (First, Middle, Last) Fire Dept. Officer 2yrs 18. Mother's Neme (First, Middle, Maiden Surname) Be Important: If fem 27 is marked or any injury or other traumatic evonce. Dorothy Johnson Arthur Hicks Sr. 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 4019 Duvall Ave, Baltimore Md Blanche Hicks-Wife 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete XX Buriel 2 ☐ Cremation 3 ☐ Removel from Stete Department C 12/23/99 Baltimore Co, 4 ☐ Donetion 5 ☐ Other (Specify) Woodlawn Cemetery 21. Signature of Fufferal Service Licensee 22. Name end Address of Fecility March F/H West
4300 Wabash Ave, Baltimore Md
23a. Part1. Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart fellure. List only one cause on each line. 21215 Approximate Interval Between Onset end Death **Physician** /Medical Immediete Cause (Final Hemorrhage FRO

Due to (or as a consequence of): FROM UPPER G.I. BLEED days disease or condition resulting in deeth) Examiner Examiner sician and burial-transit certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as a consequence of): physician Physician/Medical Due to (or es a consequenca of): the 88 Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ence phalopathy 1 Yes 2 No 3 Probably 4 Unknown troxic signed l þ 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed CIRONARY ARTERY DISEASE page 2 1 ☐ Yes 2 No certificate or Attanding Physician: Be 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) Hospitat: Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Neturat 5 Pending death. 1 ☐ Yes 2 ☐ No Investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Ptece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide filled in Hospital edical 29a. Certifiei 斌 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as steted. 2 Medical Examiner: On the basis of exemination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one) within 2 \$ 29b. Signature and fitte of certifie 29c. License number 29d. Dete signed (Month, Dey, Year) MD AS2402321-HT2982 DECEMBER 18,1999 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) Sina; HOSPITAL OF BALFIMORE 2401 W- Belvedere Ave, E HENRY TAN MD Baltimore, MD 21215 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 0 2000 ooks Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month Day Year William Thomas Jenkins 25, 1999 Dec 12:20AM 4a Facility Name (If not Institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth 3509 Twin Branches Court Silver Spring B. Dete of Birth (Month, Day, Year) April 5,1929 Montgomery K Under 1 Year 6. Şax X□ M 2□ F Birthplace (Stata or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) Hours Months 70 Yrs. 285-20-1764 Ohio Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☑ No Maryland Montgomery Silver Spring 10e. Street and Number

10f. Zip Code

1 ☐ Yes 2CXNo

Self-Employed

20b. Plece of Disposition (Name of cematery, crematory or other place)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

20906

13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

22. Nama and Address of Fecility
Fleck Funeral Home, Inc.

10g. Citizen of What Country?

Specify

16b. Kind of Business/Industry

20c. Location - City or Town, Stete

Writer

18. Mother's Nema (First, Middle, Maiden Sumame)

Bessie James

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)

Gate of Heaven Cemetery 12/29/99 Silver Spring, MD

3509 Twin Branches Court, Silver Spring, MD 20906

Date

14. Race - American Indian, Black, Whita, atc.

White

Maryland

Approximata Intervel Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

12/28/99

2 200

2 1703

20707

USA

28a-(show the Medical Examiner must be notified at 23a or natural', or Items Peges 1 and 2 should be filed within 72 hours after aitimore, Maryland 21215-0020 Hygiene. permit. Peges 1 and 2 should be filk Department of Health end Mental Hy Important: If Item 27 ia marked oth any injury or other traumatic avent

Physician

/Medical

Examiner

10e. Steta

11 Marital Status

3509 Twin Branches Court

15. Decedent's Education (Specify only highest grade completed)

1 Nevar Married 2 Merried

3 ☐ Widowed 4 ☐ Divorced

Elemantary/Secondery (0-12)

20e. Method of Disposition

17. Fether's Neme (First, Middla, Last)

William A. Jenkins

4 ☐ Donation 5 ☐ Other (Specify)

19e. Informent's Neme/Raletionship (Type, Print)

Virginia C. Jenkins/Wife

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State

a

Stanley Schwartz,

31. Date filed (Month feet) Year 2000

30. Nema and eddress of person who completed causa of death (Item 23a) (Type, Print)

32. Reduktor Simulare

MD

eea Liconsee

12. Wes Decedent Evar in U,S. Armed Forces? 1 Yes 2 No If Yas, Give

Yeer or Detes

College (1-4or 5+)

Director

Funeral

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Completed

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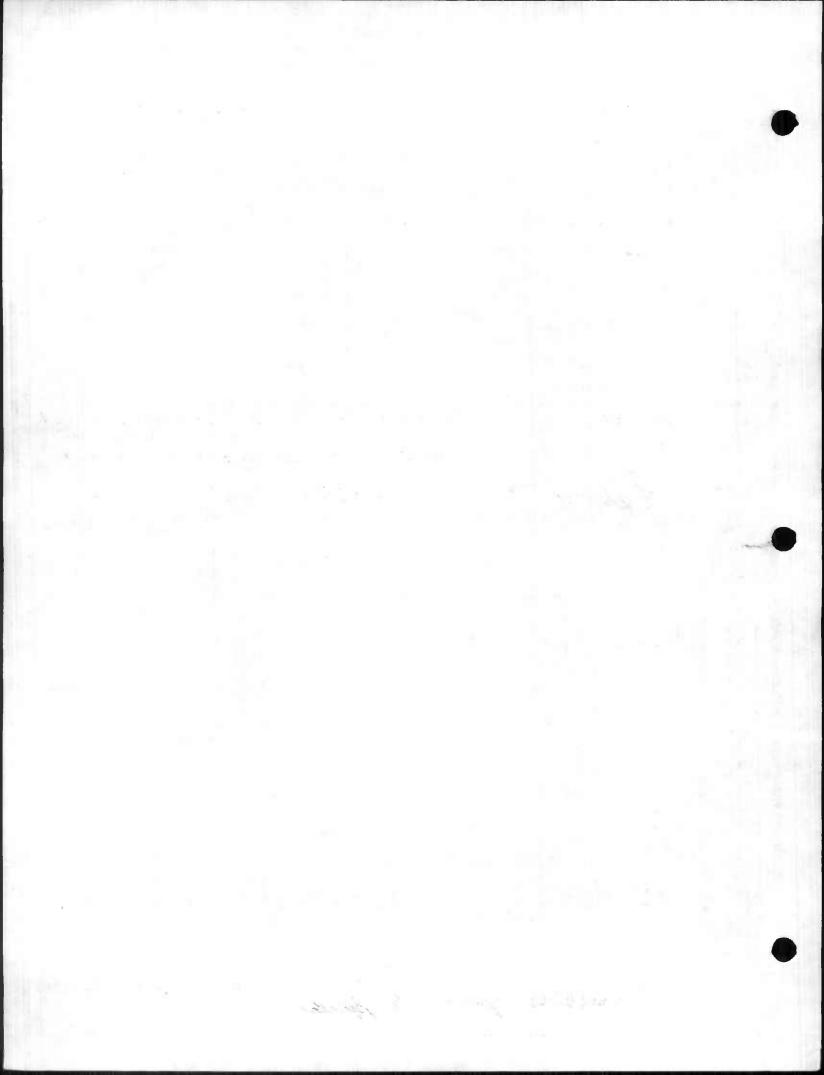
attending physician and for use as the burlel-transit 2 signed b Hospital or Attanding Physician: 24 hours after deeth. Funeral Director: After this certifica staly filled in by the funeral director, i

7601 Sandy Spring Road Laurel, The contest, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the death in a cardiac or respiratory arrest, and the contest of the cont Immedieta Cause (Finel BONTE MANNOW Parciena disaese or condition resulting in daath) Due to (or as a consequence of): Examiner MEMASTATIU CANOTEN Sequentially list conditions, if eny, leeding to immadiata cause. Enter Underlying Ceuse (Diseasa or injury thet initiated events resulting in death) Lest Due to (or es e consequence of): PROSTATE CANCEN Physician/Medical Due to (or es e consequence of): Pert ff. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? Completed 1 Yas 2 No 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 27. Manner of Deeth 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 1 DNatural 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicida 111 Certifying Physician: To the best of my knowledga, death occurred at the tima, date and place, and dua to tha cause(s) and manner as stated. 29e. Certifier (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner steted. 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

State Registrar 210] Medical Park Drive #210, Silver Spring, Maryland 20906

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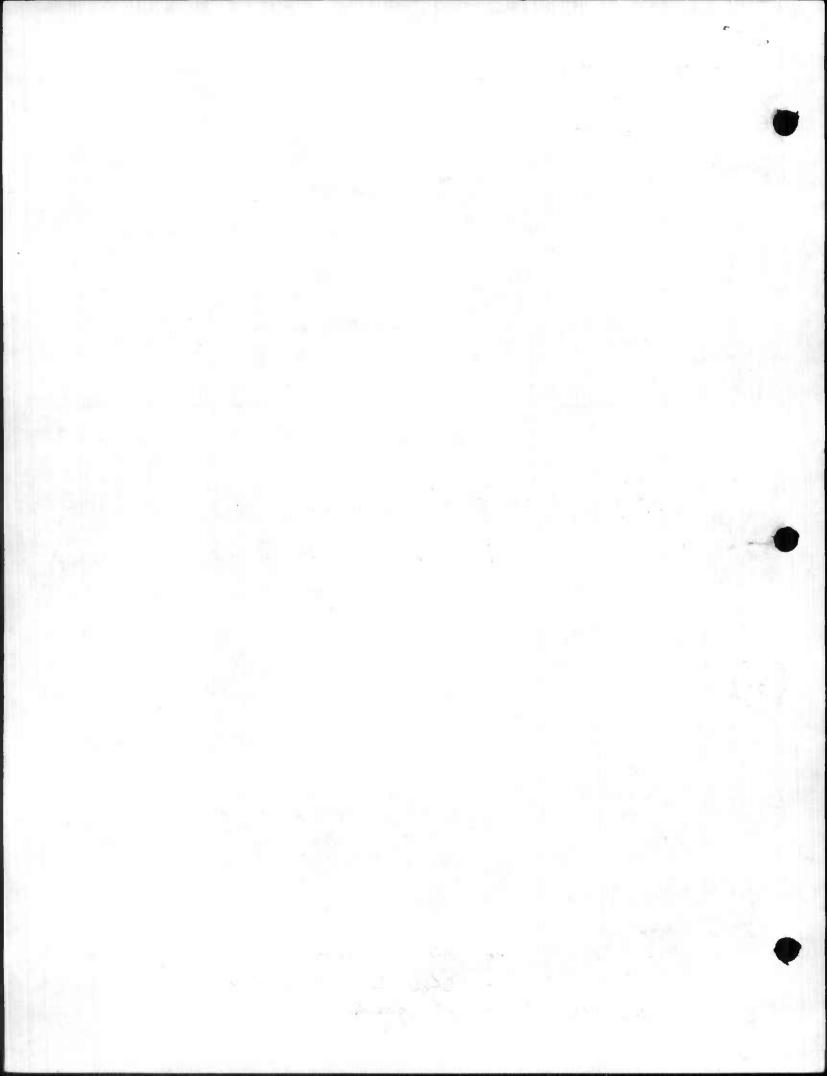


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State of Maryland / Department of Health and Mental Hygiene 99 1, 1967

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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1968 Certificate of Death AMEND#26 PER MD. G779 1-7-2000 J.A. t's Name (First) Middle, Last) 2. Date of Death 4b., Gity, Town, or Location of Death (If not institution) give street and number) If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 8829 Days Months 10 M 20 F Usual Residence of Decedent 10b. County City Town or Location 10d. Inside City Limits 1 Nes 2 No 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working file. DO NOT use retired) VUTSE 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Name /First Middle Maiden Sumame Father's Name (First, Middle, Last) 20a. Method of Disposition 1 Deurial 2 ☐ Cromation 3 ☐ F 4 ☐ Donation 9 ☐ Other (Specify) 4 Donation 21. Signature of Puneral Sedvice Licenses Interval Between Onset and Death

Physician /Med_ral Examiner

or other tn

Physician /Medical

Examiner

10a. State

Funeral

Director

na 23a or 28a-f short must be notified at

Funeral Director

Be Completed by

with the Maryland

Pages 1 and 2 should be filed within 72 hours after death next of Health and Mental Hygiene.
Inttil Item 27 is marked other than "natural", or fems 23.

Baltimore, Maryland 21215-0020

Box 68760.

Division of Vital Records, P.O.

or Attending Physician:

Be Completed by Physician/Medical Examiner certificate Certification: To 100 Affisi after death Director: At

5 Pending investigation

6 Could not be determined

23b. Did tobacco use contribute to the cause of death?

1 TYes 2 XNo 3 Probably 4 Unknown 24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one) 2 ER/Outpatient 4☐ Nursing Home 6 COther (Specify) scribe how injury occurred 1 ☐ Yes 2 [] No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29d. Date signed (Month, Day, Year)

death (ttem 23a) (Type, Print)

JAN 1 0 2000

25. Was case referred to medical

1 Yes

Natural

2 Accident

3 Suicide

4 Homicide

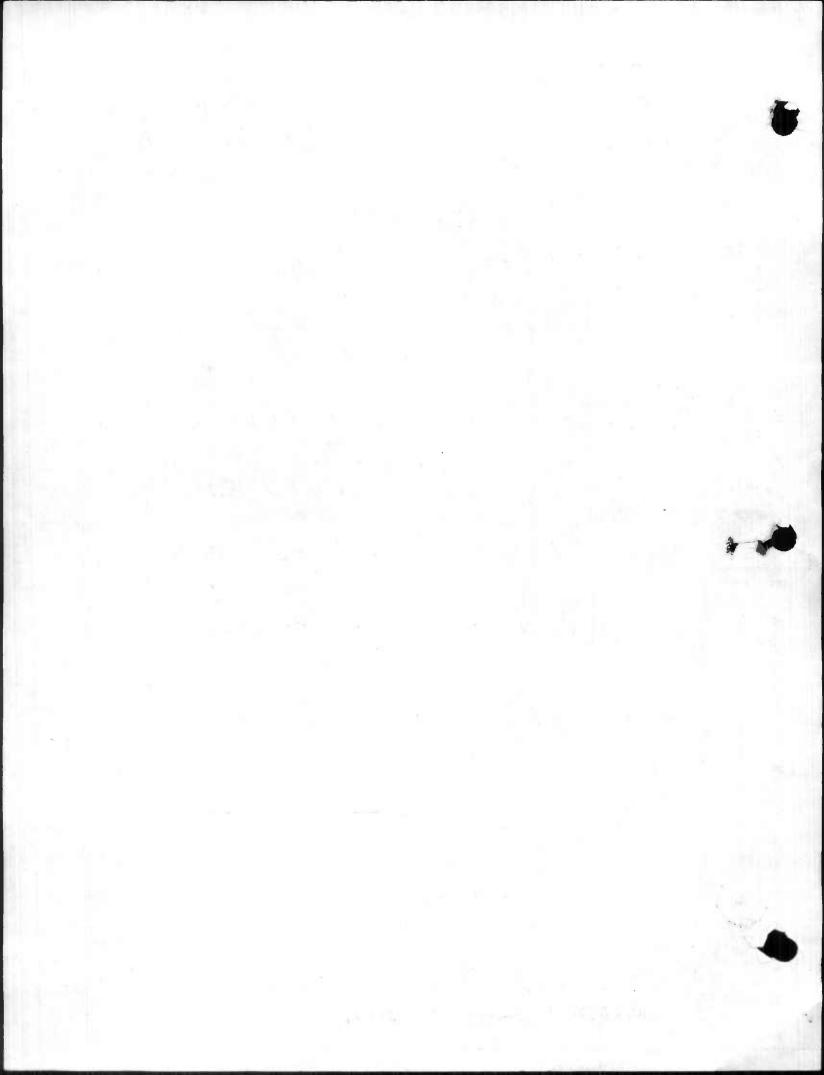
32. Registrar's Signature

1 Impatient

State Registrar

Med in by

Medical



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physician /Medical	١.	Hildreth	1 '	lille	2 -			Ma	1 27 27	Yaar gg	.45 gm
Examiner	r	4a. Facility Nama (If not institution, give Roland Park	Place)			4b. City, Town, or L Balti			of Death	City
uneral irector		5. Social Sacurity Number 6. S		ga (In yrs. 91		Under 1 Yaar onths Days		8. Data of Bir (Month, De Oct.26,	rth av. Year)		(Stata or Foraign
3	-	Usual Rasidance of Decedant 10a. Stata 10b. County		100 Ci	ty, Town or Locatio					104 1	and Oh Alasia
led at	5	MD N/A			timore						isida City Limits □*Yas 2□ No
be notified Director	3	10e. Street and Number		<u> </u>	11	of. Zip Coda			10g. Citizan of \	What Country?	
a D		830 W. 40Th Street	#302			21211			U.S.A.		
any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	5	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedan Armed Forcas 1 Yas 2 H If Yas, Giva Yaar or Datas:	?		Decedent of H , specify Cub as 2 No	dispanic Origin? (Span, Maxican, Puarto Specify:	pecify Yas or No Rican, atc.)	Specify	a - Amarican Inck, Whita, atc. White	dian,
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To Be		Gabriel	Hame	nt			Betty			(unkno	wn)
amne	1	19a. Informant's Name/Ralationship (1	ype, Print)		19b. Mailing Ad	ldrass (Street	and Number or Ru	ral Routa Numb	er, City or Town,	Stata, Zip Code	9)
or other tr		Howard Miller / Son 20a. Mathod of Disposition 1 Burial 2 Cramation 3 C	Ramoval from State	1	Placa of Disposition camatary, cremator	(Nama of y or othar pla		Data	20c. Location -	City or Town, S	Stata
in un	-	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Ва	timore Heb	new Ceme	see of Enciliby	11/29/99	Baltimor		
any ir		Scott M. Cuttler					Solostown Road		n & Bros.		
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		29a. Cartifiar 1 Certifying Phy	sician: To tha best	of my kno	wledga, daath occi	urred at tha tir	ma, data and place,	City or To	causa(s) and ma	nnar as stated.	
mpletely fil	-	one)	and mannar s	ated.	tion and/or invastig			red at tha time,	data and placa,	and dua to tha	cause(s)
2		29b. Signatura and life of chillier				29c. Licans			29d. Date signe	99	Year)
	1	80. Nama and addrass of parson who co Robert Vissing	mD. 43	daath (Itan	23a) (Type, Print)	15+ Su	vide 5 h 1	Ba (tim	V.	ND 21	218
State	;	31. Data filed (MANN Day, Geo 080	32 House	ar's Signa	iture 1	OPERA	yite 5 h 1		-0 - 6		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended Item#1 perPhy, #17, 19a perFHG779 1/10/2000 EW Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death Month December 20, 1999 George Samuel Register Regester 2:00am 4b. City, Town, or Location of Death 4a. Facility Nama (If not institution, giva street and numbar) 4c. County of Death Baltimore County 4510 Bucks School House Road Baltimore If Undar 24 Hrs. Hours Min. 5. Social Security Number If Undar 1 Yaar B. Data of Birth (Month, Day, Yeer) 1927 9. Birthplaca (State or Foreign Country) Baltimore City, Md. 7. Aga (In yrs. last birthday) 8. Data of Birth Months Days 216 24 8895 71 Yrs Usual Rasidence of Decadent 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2√ No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 4510 Bucks School House Road 21236 USA 12. Was Dacedant Evar In U,S. Armed Forcas? 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 ☐ Yas 2X No If Yas, Giva Yaar or Datas: 1 Navar Married 2 Marriad 1 ☐ Yas 2 XNo Specify: White 3 Widowed 4 Divorcad 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 15. Dacedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collaga (1-4or 5+) Self Employed Register Florist 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middle, Maiden Sumema) Samuel Register Regester Helen Kilian 19a. Informant's Nerge/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Coda) Carolyn G Register (Wife) 4510 Bucks School House Road Baltimore, Maryland 21236 20b. Placa of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata Parkwood Cemetery December 22, 1999 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility
Lassahn Funeral Home , Inc.
7401 Belair Road Baltimore, Maryland 21236 23a. Part. Enter the disease or complications that caused be death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Onset and Deeth Immediata Causa (Final disaasa or condition rasulting In daath) PROBABLE ARRHYMIA Dua to (or as a consequence of): Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Causa (Disaasa or Injury that initiated avants resulting in daath) Last Dua to (or as a consequence of): Dua to (or as a consequence of): Part II. Other algnificent conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 1 No 3 Probably 4 Unknown 24b. Ware autopsy findings available prior to completion of cause of deeth? 24a. Was en eutopsy performed? 1 Yas 2 INO 1 Yas 2 LNO 25. Was casa rafarred to medical axaminar? 26. Placa of Daath (Chack only ona) Hospital: Othar: 4 ☐ Nursing Homa 5 ☐ Hasidanca 6 ☐ Othar (Specify) 1 Yas 2 NO 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Daath 28b. Time of 28d. Dascribe how injury occurred 28c. Injury et Work? 1 Matural 2 Accident

burial-transit certificate be axecuted and Box 68760. ettanding physician for usa as the buria P.O. the Division of Vital Records. peen has page 2 Hospital or Attending Physician: 24 hours ettar death. Funeral Director: After this certifica funeral

Physician⁴

/Medical

Director

Funeral

by

Completed

Examiner

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Director

itam 27 is markad other than "natural", or items 23a or 28s-f show other traumatic event, the Modical Examinar mast be notified at

2 should be filed within 72 hours efter end Mental Hygiena. Is merkad other than "natural", or ite

Department of Health and Important: If Itam 27 is many injury or other traum once.

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P

Medical Certification:

Baltimore, Maryland 21215-0020

the Maryland

5 Panding Investigation

6 Could not be datamined

28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify)

1 Yas 2 No

28f. Location (Streat and Number or Rural Routa Number, City or Town, Steta)

29a. Cartifian (Check only one)

3 ☐ Suicida

4 Homicida

1 Cartifying Physician: To the bast of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner es steted.
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of 56

29c. Licansa number

29d. Data signed (Month, Day, Yaar)

nplated causa of daath (Item 23e) (Type, Print)

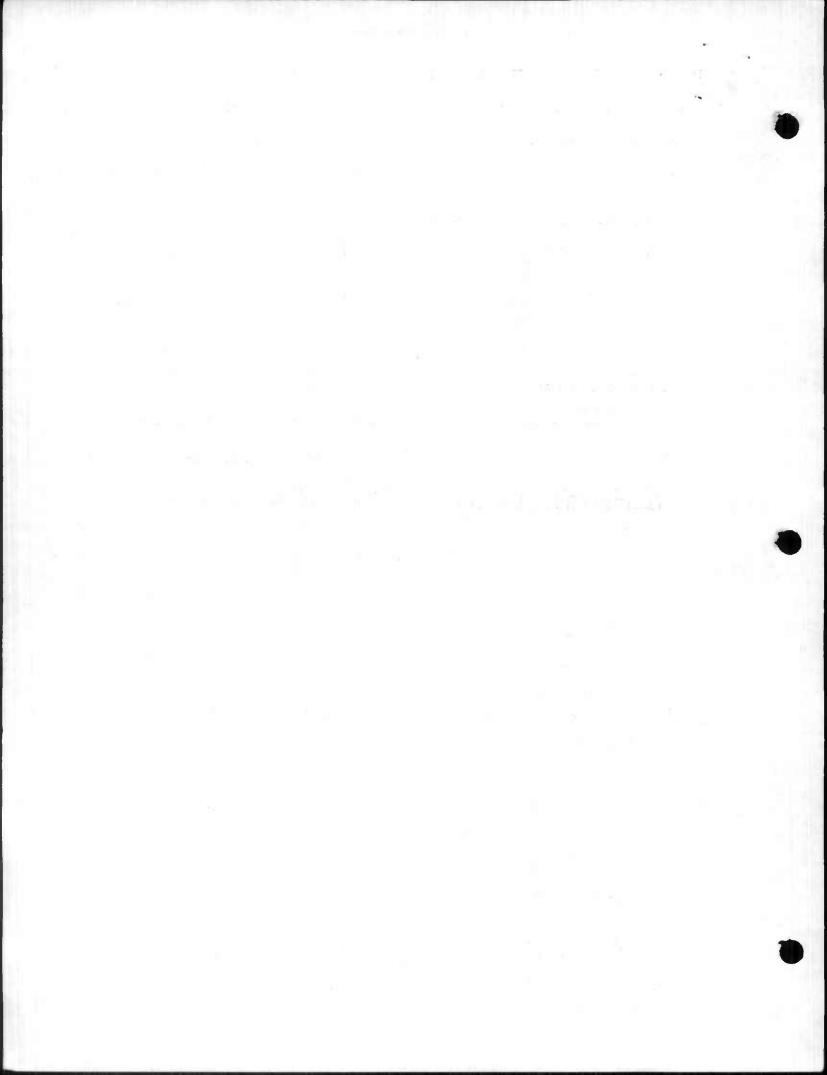
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JAN 1 0 2000

32. Ragistrar's Signatura

State Registrar

24 hours e

within 2



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Dev Year Month Jada Shirley Williams December 24, 1999 7:37 p.m. 4e Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Cheverly Prince George 8. Data of Birth (Month, Day, Year) Dec. 24,1999 If Under 1 Year 5. Social Security Number If Under 24 Hrs 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) Days 1 M 2 KF Months Hours Yrs N/A Maryland Usual Rasidence of Decedent 10a. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yas 2 □ No D.C. N/A N.W. Washington, D.C. 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 34 Sherman Circle 20011 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Merital Status Black, Whita, atc. 1 ☐ Yas XX No If Yas, Giva Year or Dates: XX Nevar Married 2 Married 1 Yas 2 No Specify: Specify: Black. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) 0 Infant Infant 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Vincent A. Williams Cheryl Moore 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Cheryl Williams/Mother 34 Sherman Circle, N.W. Washington, D.C. 20011 20b. Place of Disposition (Nama of cematary, crematory or other place) 20e. Mathod of Disposition 20c. Location - City or Town, Stata Data 17☐ Burial 2 ☐ Cramation 3 ☐ Removat from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Maryland National Cem. 12/20/99 Laurel, Maryland 22. Nama and Addrass of Fecility Fleck Funeral Home, Inc. 7601 Sandy Spring Road, Laurel, Maryland 20707 disaase, or complications thet ceused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, Approximate failure. List only one ceuse on each line. Approximete Interval Between Onset end Death Immediata Cause (Finel disaasa or condition rasulting in deeth) SEVERE IMMATURITY GESTATION 22 WEEKS Sequentially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 | Yee 2 No 3 | Probably 4 | Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to medical examinar? 26. Place of Deeth (Check only one) 1 Yas 2 No 1 Inpatient Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 2 ER/Outpatient 3 DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funerai

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Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumedc event, the Medical Exameter must be notified at

the Maryland

WITH

death

72 hours after

permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "naturet", any Injury or other traumatic event.

Baltimore, Maryland 21215-0020

Box 68760

Division of Vital Records, P.O.

the burial-transit and Physician/Medical 92 by 8 Completed Be P Certification:

edicai

State Registrar 29a. Cartifias (Check only one)

physiclan Deen has certificate Hospitat or Attending Physician:
24 hours after death.
 Funeral Director: After this certific

27. Menner of Deeth 1 BNatural

29b. Signeture and title of certifier

2 Accidant 6 ☐ Could not be 3 ☐ Suicide 4 Homicide

28a. Date of Injury (Month, Day Year) 5 Pending invastigation

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28b. Tima of

28d. Describe how injury occurred 28c. tnjury at Work? 1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

1B/Certifying Physician: To the best of my knowledga, death occurred at tha time, date end plece, and due to the ceuse(s) and mennar as stated.

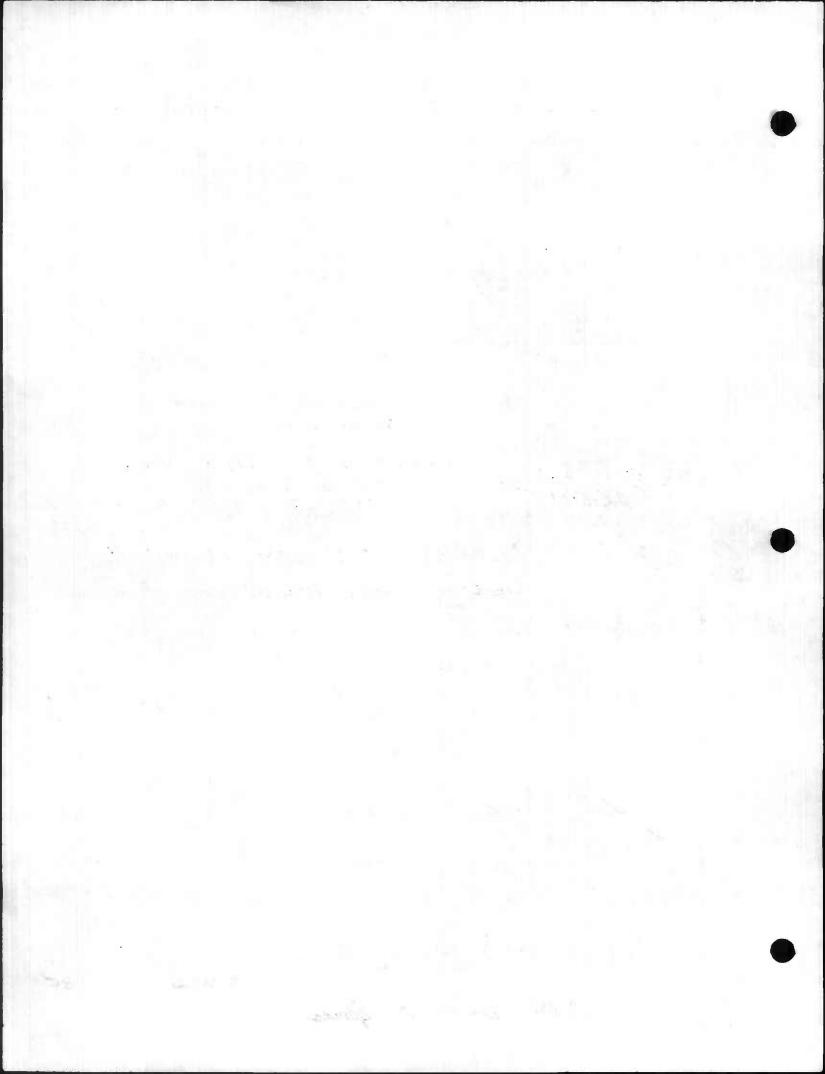
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and manner stated. 29c. Licanse number 29d. Data signed (Month, Day, Year)

Drive, CHEVERLY,

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) FORWFOD 3001 HOSP mi)

32. Registrar's Signetura

To the P within 2



Examiner **Funeral** Director 10a. Stete 25a-f show must be notified at Director 8 Berne 23e Funeral hours after "natural", or Baltimore, Maryland 21215-0020 ģ Completed filled within 7 Hygiens. other then "n Pages 1 and 2 should be filled w Department of Health and Mental Hygien Important: if them 27 is marked other the Be

Abbott

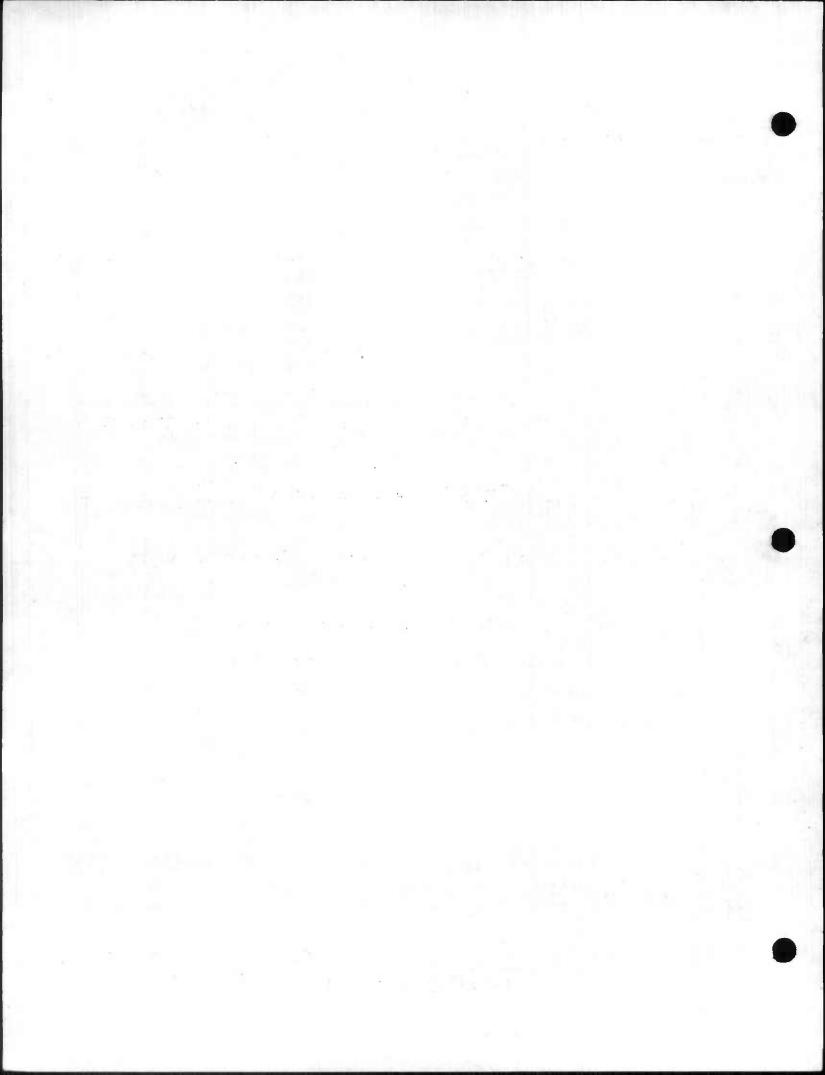
Virginia

Marie

State of Maryland / Department of Health and Mental Hygiene Q Q Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 24 1999 10:53 AM MARIE VIRGINIA December /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 □ M 2 🖾 F Hours 79 214-28-6168 MARYLAND Usual Rasidence of Decedent 10b Count 10c City Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MARYLAND WASHINGTON KEEDYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4102 CHESTNUT GROVE ROAD 21756 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien. Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 M No Specify: 3 Widowed 4 □ Divorced WHITE 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) ASSEMBLER AIRCRAFT MANUFACTURE 17. Father's Neme (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumama) OTHA T. ROHRER MARY M. EBERSOLE 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) GLORIA J. WINEBRENNER/DAUGHTER 4106 CHESTNUT GROVE ROAD, KEEDYSVILLE, MD 21756 20b. Plece of Disposition (Nama of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cramation 3 □ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 12/28/99 SHARPSBURG, MARYLAND MOUNTAIN VIEW CEMETERY 21. Signeture of Funaral Service Licensee 22. Nama end Address of Facility STUM 7606 Old national Pike BAST FUNERAL HOME P. Steven Danfelt Or. Boonsboro, Maryland 21713 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximeta Intarval Between Onset end Death Physician /Medical Immediata Ceuse (Final diseesa or condition resulting in death) . SYSTEMIC INFLAMATORY RESPOND SYNDROME Examiner Examiner PERITONITIS physician and the burial-transit Sequantially list conditions, if eny, leading to immadiate cause. Entar Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): DISEASE END RENAL STAGE Physician/Medical Due to (or as a consequence of) KIDNEY DISEASE TIC POLYLYS Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 No 3 | Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Was en autopsy performed? peed 1 Yes 2 No 1 ☐ Yes 2 ☐ No after death.

Director: After this certific 25. Was case referred to medical examinar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yas 2 No 1 N Inpatient 2 ER/Outpatient 3 DOA Division of 27. Menner of Death 28d, Describe how injury occurred 28a. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Panding investigation 1 Netural 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be determined 3 Suicida within 24 hours after de To the Funeral Directo completely filled in by # 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicida 29a. Cartifier 18 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to tha cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data end place, and due to the cause(s) end manner steted. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier an 12/24 30. Neme end eddrass of person who complated causa of death (Item 23a) (Type, Print) Avenue Hagerstown 12931 Hill MIONZUY Oak 31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture State 1999 **DEC 27** Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Year **Physician** 4b. City, Town, or Location of Death 1999 0008 Lu Ann Armstrong /Medical 4c. County of Death 4e Facility Name (If not institution, give street and number) **Examiner** Hagerstown Washington Washington County Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 18, 1955 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Months 1 M 2 F Yrs. 44 Maryland Director 213-68-6453 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 25a-f show NYes 2□No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 'hatural', or herra 23a 21742 HSA 336 Belview Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Detes: 14. Rece - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Meritel Status 1 Never Married Merried 3altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White Àq 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Credit Analyst 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be h and Mental h L. To O'Neal Albert Sines Mary Jane 19e. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m 21742 Paul Armstrong-Husband 336 Belview Avenue Hagerstown, Maryland 20b. Pleca of Disposition (Nema of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1XX Burlel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 12-27-99 Hagerstown, Maryland Rose Hill Cemetery 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Usborne Funeral Home, P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** /Medical immediate Cause (Final a. ENO STACE ALCOHOL LIVER DISEASE WITH LINGS diseese or condition resulting in death) I WELK Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as e consequenca of). Due to (or es a consequença of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown SEPTICEMIA Records, by 8 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed COAGULOPATHY 1 Yes 2 No 1 □ Yes 2 □ No RENAL FAILURE CONGESTIVE HEALT FAILURE Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case raferred to medical Be 26. Place of Deeth (Check only one) exeminer?
1 Yes 2 No Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manper of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homleide 1 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edical 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 251395 William E. Royster Jr. M.D. 11110 MEDICAL CAMPUS P.D. SUITE 107 . HACEISTONN, MO 21742
31. Dete filed (Month, Dey, Year)
32. Registrer's Signeture

DHMH 16 Rev 6/95

State

Registrar

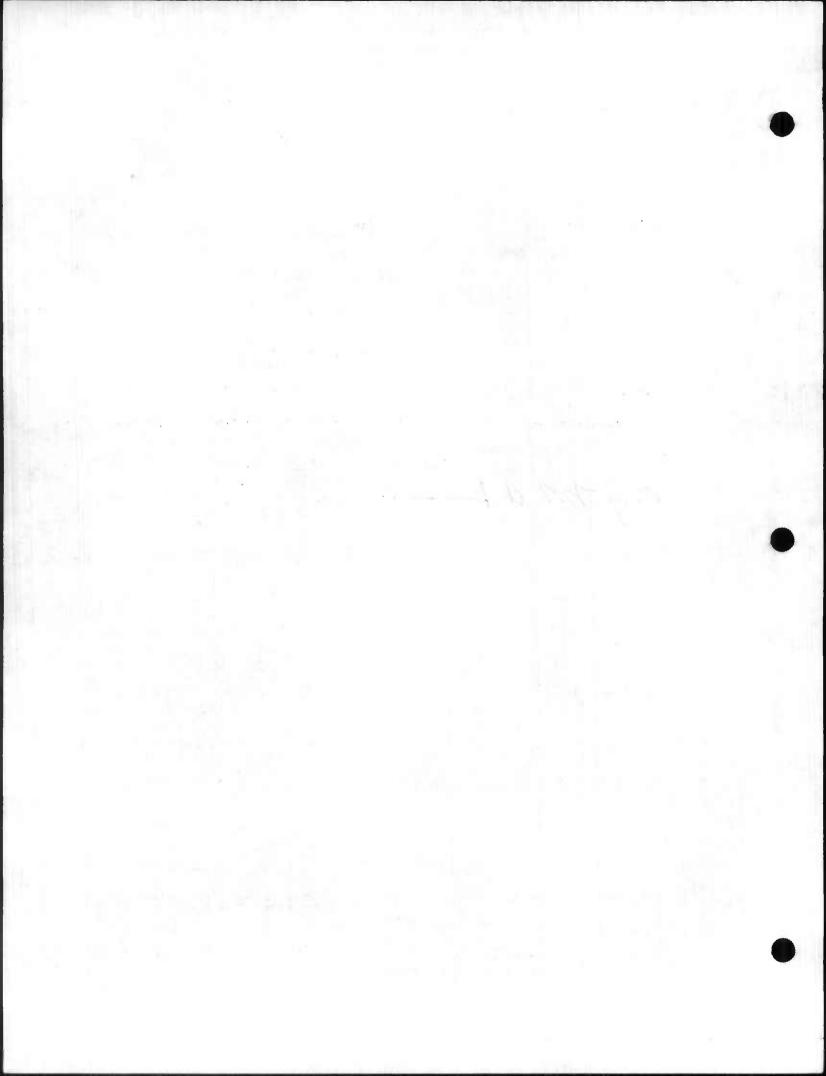
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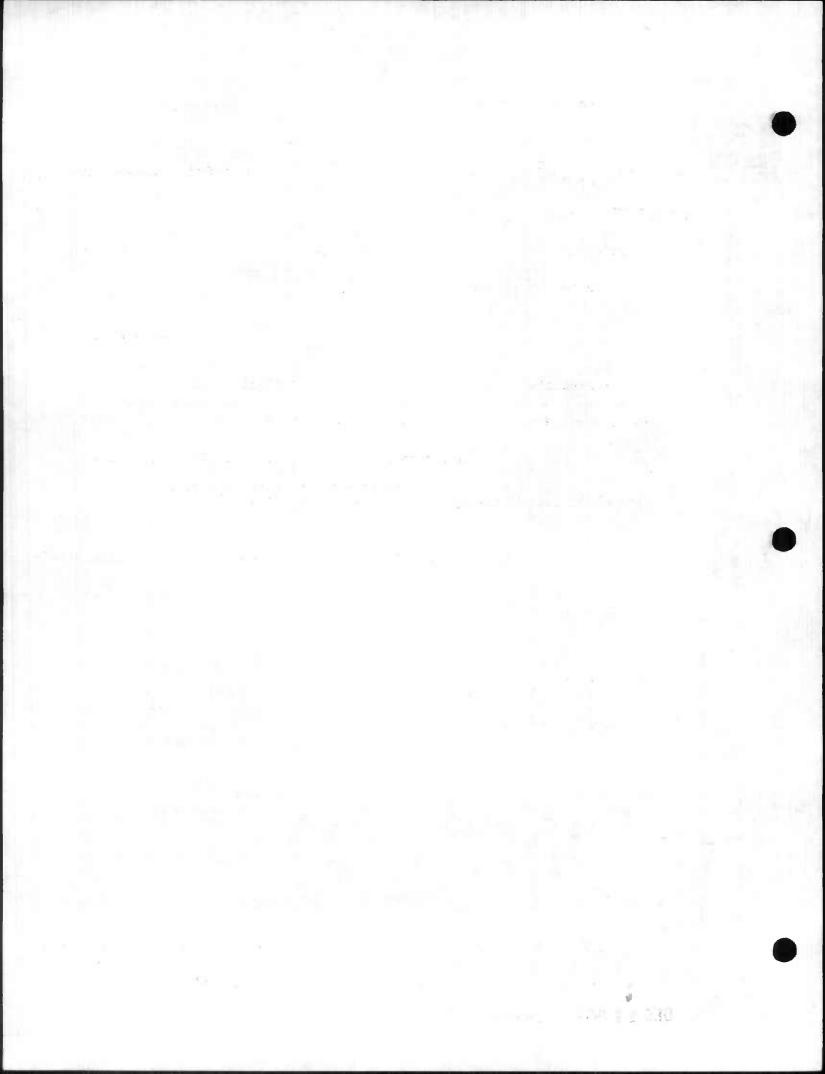


State of Maryland / Department of Health and Mental Hygiene 41974 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** Horace Linton Adams December 21 1999 1905 P /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 150 Providence Road Elkton Cecil If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1[XM 2] F Yrs. 218-01-3852 December 28,196Maryland Director Usual Residence of Decedent the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ahow edical Examiner must be notified at Director Maryland Cecil Elkton 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 150 Providence Road 21921 United States Funeral death 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. should be filed within 72 hours after and Mental Hygiene.
marked other than "natural", or fiel unade event, the Medical Exercise. 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: 1 Never Married 2 X Married 21215-0020 1 Yes 2 XNo Specify: Specify: White by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Manufacturing Elementary/Secondary (0-12) College (1-4or 5+) Millwright 3 Baltimore, Maryland 17. Fathar's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Peges 1 and 2 should be finent of Heelth and Mental I int: If Item 27 is marked of Isabelle Kelly Benjamin Franklin Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara M. Adams/Wife 150 Providence Road, Elkton, Maryland 21921 Item 2 other 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State permit. Peges Department of Important: If It any Injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) John's Methodist Cem. 12/24/99 Lewisville, PA 22. Name and Address of Facility 21. Signatura of Funeral Service Licenses Hicks Home for Funerals, P.A. 103 W. Stockton St., Elkton, MD 21921 23a. Part 1. Entar tha disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceuse on each line. Approximete interval Between Onset and Death **Physician** /Medical fmmediate Cause (Final Critical Aortic Valve STENOSIS disease or condition resulting in death) MONTHS Examiner Due to (or as a consequence of): Examiner sician and burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting In death) Last Due to (or as a consequence of): Box 68760, physician the buria Physician/Medical Due to (or as a consequence of): 88 980 P.O. Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 PNo 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Division 1 AtVetural 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendition within 24 hours after deeth.
To the Funeral Director: A completely filled in by the fi deeth. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1년 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Monte Makon, MD D-44783 December 22, 1999 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) 6 High street, ELATON, MD 21921 MONTE MAKOUS 111 West MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

DEC 23 1999



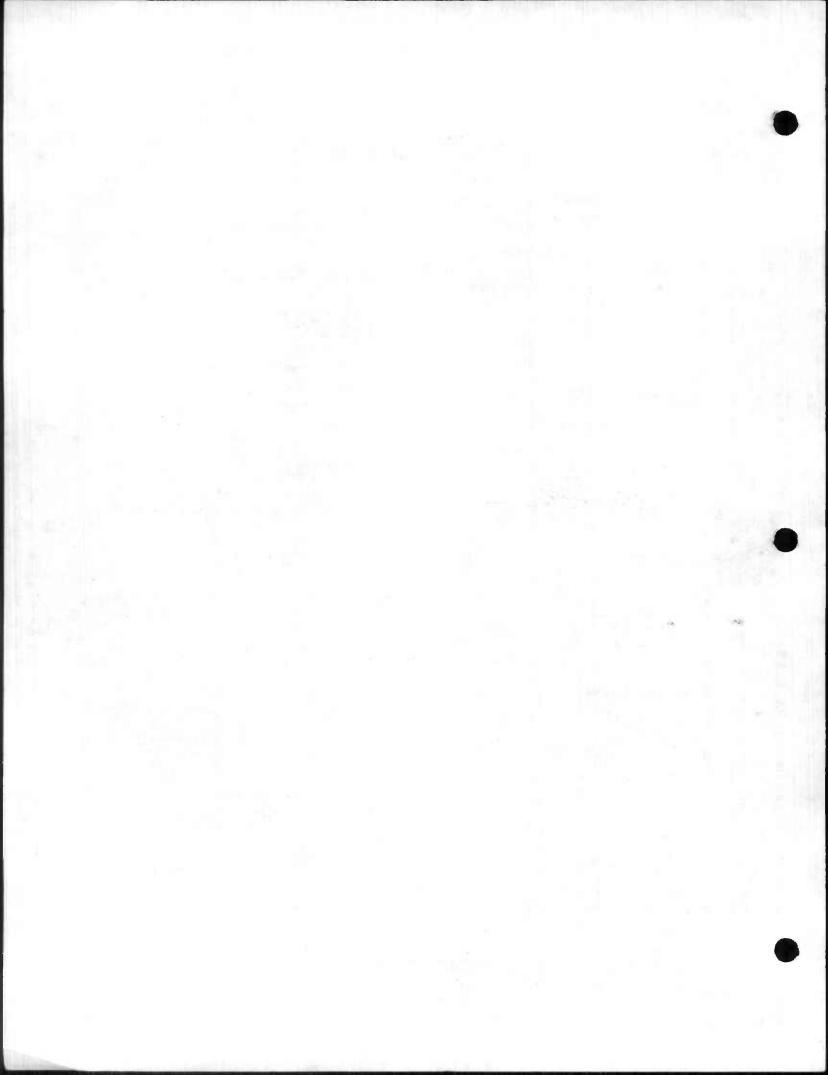
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1. Decedent's Name (First, Middle, La	st)		ficate of		2. Date of Death			me of Death
Ш	Physician /Medical	Wendell Lowri	e Anderson				Decemb	,	Year 1999	12:05PM
	Examiner	4a Facility Neme (If not institution, giv				4b. City, Town, or		4c. County o		
		9254 Mimosa D				La Pla	ta Charles			
	Funeral Director	5. Social Security Number 210-12-2454 Usual Residence of Decedent	7. Age (In yr.		f Under 1 Year lonths Days			Year) 8, 19	9. Birthplace (S Country) 22 Penn:	tete or Foreign Sylvania
	land	10a. State 10b. County	10c. C	City, Town or Locati	ion				10d. Insi	de City Limits
	Mary Lish tor	Maryland Charles	La	Plata					1 🗆	Yes 2 No
	th with the Ma 23a or 28a-f s at be notified				101. Zip Coda 20646			g. Citizen of Wi	hat Country?	
020	filed within 72 hours after death with the Maryland Hygiene. Iffer than "naturel", or items 23s or 28s-f show ent, the Wadical Examinet must be notified at a Completed by Funeral Director		12. Was Decedent Ever in Amed Forces? 1 Ayes 2 No If Yes, Give Year or Dates: 194	USN	S Decedent of I es, specify Cub Yes 2 XNo		Specify Yes or No- to Rican, etc.)		- American Indi , White, etc. White	en,
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D	tal Hyge dies					18. Mother's Na	me (First, Middle, M	laiden Sumeme)	
ıryla	2 should be 1 and Mental I is marked or reumatic eve	Robert Gerard	Anderson	19b Mailing A	Addrass (Stree	Elizabe		City or Town S		
	D = 72									
re,	~ 7 5 5	20a. Method of Disposition	20b.	Place of Disposition	on (Neme of					ate
E	Pagas nent of nt: If its nry or o		Removal from Stata				/1/03/200	Chelte	enham,	Maryland
Baltimore,	permit. Pagas Department of I Important: If Its any Inlury or or any Inlury or or	20a. Method of Disposition 1 A Burial 2 Cremation 3 Removal from Stata 4 Donestion 5 Other (Specify) 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Maryland Veterans Cemetery1/03/2000 Cheltenh 22. Name and Address of Facility The Huntt Funeral Home, Inc., Post 0 156, Waldorf, Maryland 20604-0156 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.								
	Jok	23a. Part1. Enter the disease, or com		ath. Do not enter the	he mode of dy	ing, such as cardia	c or respiratory arre	st,		ximate al Between
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68760,	tificate be executed g physician and as the burial-transit	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	c	(or as a consequer						
	T oug	resulting in daath) Last	d.	(or as a consequan	nce of):					
	death	Part II. Other significant conditions of	ontributing to death but not re	esulting in the unde	rlying cause gi	ven in Part I.	23b. Did to	bacco use con	tribute to the ca	use of death?
s, P.O	requires that the death cert seen signed by the attendin hould be detached for use.						1 □ Ye	s 2 No	3 Probably	4 Unknown
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	vithin Fo the sompl	29b. Signature and title of certifier	00-		29c. Licen			d. Date signed	(Month, Day, Y	ear)
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		Vidyasagar Anmangandla, MD, P.O. Box 282, Charlotte Hall, M								

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Examiner	4a Facility Name (If not institution, git SOUTHERN MARYLAN	51/21/51/51/51	משישוי		CLINTON	Location of Death	4c. County of	E GEORGE'S
Funeral Director	5. Social Security Number 6. 3		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs		Year)	9. Birthplace (State or Foreign Country) Maryland
2	Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo	postion		1200	1000	10d. Inside City Limits
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effer deeth with the Menyland or flame 23s or 28s-f show mitter maint be notified at Funeral Director	10e. Street and Number 14991 Poplar Hil	,	Waldoll	10f. Zip Code	20601	1	0g. Citizen of W	
	11. Merital Status	12. Wes Decedent Ever in Armed Forces?	U,S. 13.	Was Decedeni of if Yes, specify Cul		Specify Yes or No- rto Rican, etc.)	14. Race	- American Indian,
	1 Never Married 2 Merried 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give 2 Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specify:	White
	15. Decedent's E (Specify only highest grant Elementary/Secondary (0-12)		(Give		pation during most of wo ed)	orking	16b. Kind of Bus	
D PET O	5 17. Father's Name (First, Middle, Last)	Farm	ner	18. Mother's Ne	me (First, Middle, i	Farming Maiden Sumame	<i>'</i>
Nore, Maryland 212: ges 1 and 2 should be filed within it of Heelith and Menis! Hydene. If item 27 is marked other than or other treumatic event, the III TO Be Compi	George W. Adams				Mary	V. Robey	Adams	
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Baltimore, Me permit. Peges 1 and 2. Department of Heelih es Important: if them 27 is eny injury or other trea	William M. Adams 20a. Method of Disposition			Ripley I	Road La F	Plata, MD	20646	City or Town, Stata
Baltimore semit. Peges 1 o Separament of He mportant: If New my Injury or oth	1 Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specie	Removel from State	cemetery, crei	netory or other ple		12-31-99		
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n aaesa	1 John Ad	M00173				al Servi		ND 2000E
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/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	a. Conges Due to	ti oc	Hear	t fai	ilure		Admitted
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Attending or deeth. ector: After by the fune	1 Natural 5 Pending 2 Accident investigatio	n	Injury		ork?]Yes 2□No			
To the Hospital or Attending Physiolen: The lawfiling & Dours effect death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page? Medical Certification: To Be Com	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Plece of Injury - At building, etc. (Spe	home, farm, str cify)	eet, fectory, office		28f. Location (S City or Town		er or Rural Route Number,
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	Holish Ju	nani.		D3	5295		12/28	8199
	30. Name and address of person who				00 0-0	2-5 1 1	10000	4400-1-3
Canto	SATISH JUMAN 31. Date filed (Month, Day, Year)	32. Registrar's Sig		VICES "	216:	708, WH	トレングイン	MD20603.
State Registrar	DEC 3 0 19			Ann.	1.1			

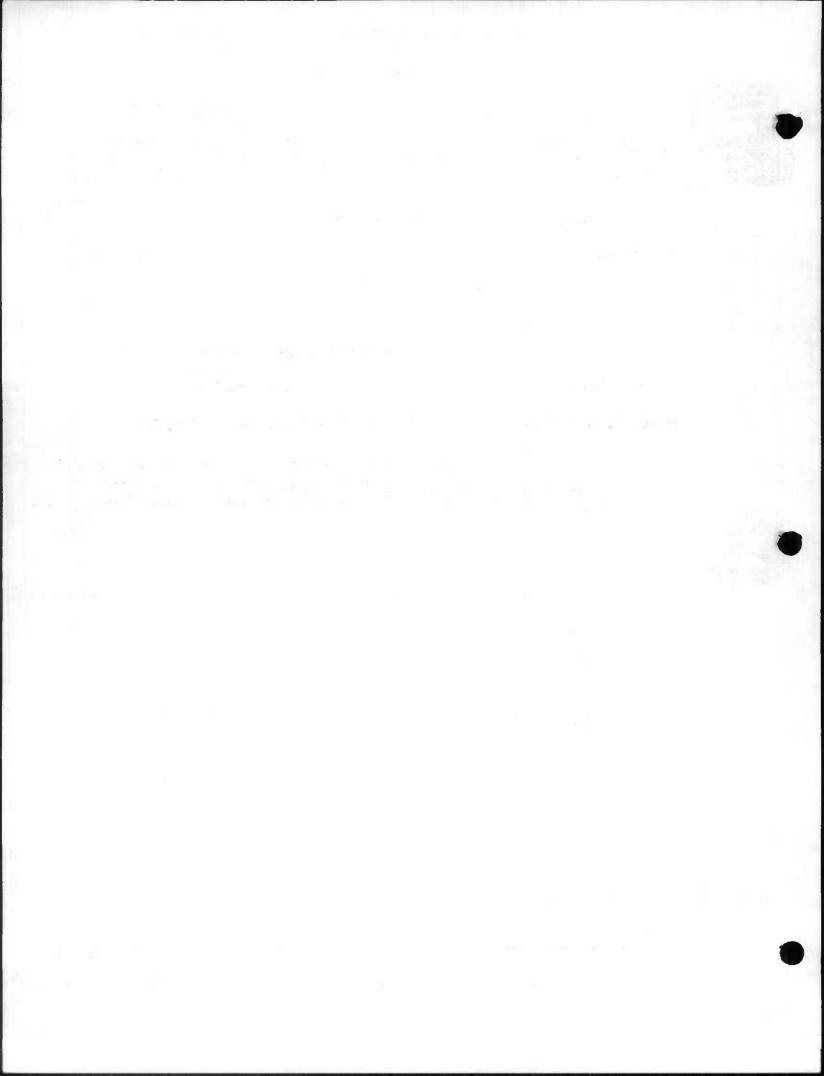


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State of Maryland / Department of Health and Mental Hygiene 99 4 978

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		Э	1. Decedent's Name (First, Middle, Las	st)						2. Date of De		Voor	3. Time of	Death
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	pu &		Usual Residence of Decedent 10a. State 10b. County		100 City 7	Town or Loc	ation						04 1-14-0	A . I I - 24-
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	Ne M	Director	Maryland Howard			Ellic		_	'					201140
	it it	ă	10e. Street and Number				10f. Zip	Code			10g. Citizen of \	What Coun	try?	
	23a	<u>a</u>	9584 Old Route 10	8		.,		2104			Unite	d Sta	ites	
	ep	Funeral	11. Marital Stetus	12. Was Decedent I Armed Forces?		13. V	Ves Deced Yes, spec	dent of F cify Cub	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No lo Rican, etc.)	- 14. Rac Ble	ck, White,		
21215-0020	filed within 72 hours after death with the Marylend Hygiene. ther than "natural", or flems 23a or 28a-f show int, the Mod ral Examinet must be notified at	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 1 N If Yes, Give Yeer or Detes:	No	1	☐ Yes 2	2 🔯 No	Specify:		Specify	y: Whi	te	
0	2 hou		15. Decedent's Ed	ucetion		16a. Deced	ent's Usua	al Occur	pation		16b. Kind of B			
15	in 7	Completed	(Specify only highest gra	de completed)		(Give I	kind of wor O NOT us	rk done se retire	pation during most of world)	rking			,	
212	filed with Hygiene. Ither then	E	Elementery/Secondary (0-12)	College (1-4or 5)+)				vchiatri		Hosp	ital		
	be filed itel Hygi d other event,		17. Father's Name (First, Middle, Last)						18. Mother's Nar		-			
Maryland	D 25 D 9	To Be	Nelson Sullivan						Gertrud	e Smally	rood			
37	d 2 should by th end Mente 7 Is marked treumatic ev	-	19a. Informant's Name/Relationship (vpe, Print)		19b. Mallin	a Address	Street	and Number or Ru	ural Route Numb	er. City or Town.	State, Zip	Code)	
×	and 2: eelth er n 27 is		Thurman A. Barth/	**			_		e 108 El		-			
ā,	- T 5 5		20a. Method of Disposition	0011	20b. Pled	e of Dispos	sition (Nan	ne of	!	Date	20c. Location			
Baltimore,			Burial 2 Cremation 3 C			etery, crem					-111			
臣	it. P		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Servica Lican		Good	Snen	nera	Cem	etery 1	2-27-99	ETTICO	tt C1	ty, M)
Ba	permit. Page Depertment of Important: If any injury or once.		Sham a (Olino-V	ithe	2 H	arry 112 c	H. N	ssof Facility Witzke's Columbia	Family Pike El	Funeral	Home City	, Inc.	1043
			23a. Part 1. Enter the disease, or companies shock, or heart feilure. List only	plications that caused	the death.							ore,	Approximate Interval Bets	
4	Physician		allock, of fleet fellate. List only	one cease on each in	10.							1	Onset and I	Death
	/Medical		Immediete Cause (Final disease or condition	100]	-0	
п	Examiner		resulting in death)	a. All	Due to (or a	s a consequ	uenca of):	-					day	
	n =	ner		a. Alp b. decu	0 1		0 -		1			1	1.00- 1-	
	rificete be executed ng physician and est the buriel-transit	Examiner	Sequentially list conditions.	b. access	Due to (or a	s a consequ	uence of):	20	year				Wille	
0	e exe	ŭ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):									i		
68760,	ate by	edicai	that initiated events resulting in death) Last	C	Due to (or as	s a consequ	uence of):					+		
9	E 00	Me										 		
Box	deeth cert e ettendin kd for use	an		d										
	dee de ett	sici	Part II. Other significant conditions co	entributing to death bu	ut not resultin	ng in the un	derlying c	ause giv	ren in Part I.	23b. Did	tobacco use co	ntribute to	the cause o	of death?
P.0	that the dended by the e	Physician/M	-1 1							10	Yes 2 No	3 Prot	ably 4	Unknown
S,	es tha igned be de	by F	Stroke,	old										
Record	v requires that been signed b should be deta	ompleted									en eutopsy rmed?	ava	ere autopsy f ailable prior t	0
ec	2 S S	ple			,							of o	npletion of c death?	ause
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of Vital	ician: The certificate rector, pay	Be	25. Was case referred to medical exeminer?						26. Place of Dea	ath (Check only	one)	1		
-	0 0	To	1 ☐ Yes 2♥ No	Hospital: 1 Inpatie	nt 2 EF	VOutpatient	3□ DO	Oth Oth	ner: 4 \(\text{Nursing H}	lome 5 Res	dence 6 □Oth	ner (Specif)	1)	
			27. Manner of Deeth 12 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28	Bb. Time of injury	2	8c. Injui	y at	28d. Describe	how Injury occur	rred		
Ö	Attending or death.	atic	2 ☐ Accident investigation			,,	М		Yes 2 □ No					
Division	er de recto by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Inju-	ry - At home	e, farm, stre	et, factory	y, office		28f. Location (Street and Num.	ber or Rura	Route Num	ber,
	is off is off al Dia	Cer		bunding, ord	. (opoury)					0.1, 0.10	, 0.12,0,			
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fr	edical	29a. Cartifier Control Check only one) Certifying Physics Certification Phy	raician: To the best of	exemination	dge, deeth	occurred a	at the tir , in my o	ne, date and place	, and due to the irred et the time,	cause(s) and made,	anner as st and due to	ated. the ceuse(s)
	thin the mpie	Med	29b. Signature end title of certifier	and manner ste	ned.		200	: Licens	e number		29d. Date signe	nd (Month	Day Veerl	
	F ₹ ₹ 8			7,00000-	N)								
	1.		Jaurena RSallager, MD DO1786 December											
	V		30. Name and address of person who of LAURIZIKE RG			3a) (Type, F	Print)	1		. /	1		di i	112.1
						-11	011	aid	en Chol	cehan	e pa	40	1600	11278
	Sta Registr	-	31. Date filed (Month, Day, Year) DEC 2 7 1	999	r's Signetur	4		1	len Choi		/			



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Neme (First, Middle, Last) 2. Date of Death December 24 1999 **Physician** MAUDE ELIZABETH BROWN /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 20 F Months 83 190-12-9880 Director March 17 1916 PA Usual Residenca of Decedant 10a. State 10b. County 10c. City. Town or Location r 28a-f show 10d. Inside City Limits TYPOS 2□No Lancaster Director Lancaster the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? me 23a or 1919 N. Eden Rd. 17601 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Neme Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Stetus Bleck, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried 21215-0020 9 white 1 Yes 2X No Specify: Specify: þ 3 Widowed 4 □ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) Public School Teacher Baltimore, Maryland 18. Mother's Name (First, Middle, Maidan Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Haalth and Mental B. Ellis Weaver Ella Mae Howser 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a. If from 27 is or other tra 20813 Apollo Lane Gaithersburg, MD. 20882 Linda Garrett 20b. Ptace of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burlat 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or 4 □ Donation 5 □ Other (Specify) Longenecker's Cem 12/29/99 W.Lampeter Twp PA. 22. Name end Address of Fecility 21. Signeture of Funeral Service License Galena F.H. of Stephen L. Schaech M00510 235 Galena, MD 21635 mode of dying, such as cardiac or respiratory arrast, Box tions that caused the death. Do not enter cause on each line. Approximata Intervel Between Onset and Death Physician /Medical Immediate Cause (Final HAEMORRHAGE C.EREBRAL disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner REPLACENENI MITRAL VALUE the bunal-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Ceuse (Disease or Injury that initiated evants resulting in death) Last Due to (or as a consequence of) CORONARY ARTERY DISEASE Physician/Medical Due to (or as a consequence of) USB ES been signed by the atter should be detached for Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 2 NO No No 1 Tes 1 Yes cartificata or Attending Physician: funaral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA Aftar this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death To the Funeral Director: A 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 28e. Ptaca of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[In the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifian (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 14 30. Name and address of person/who completed cause of deeth (Item 23a) (Type, Print) 16 GOSWANI ALPANA M.D 10901 CONNETICUT AVE KENSINGTON

DHMH 16 Rsv 6/95

State

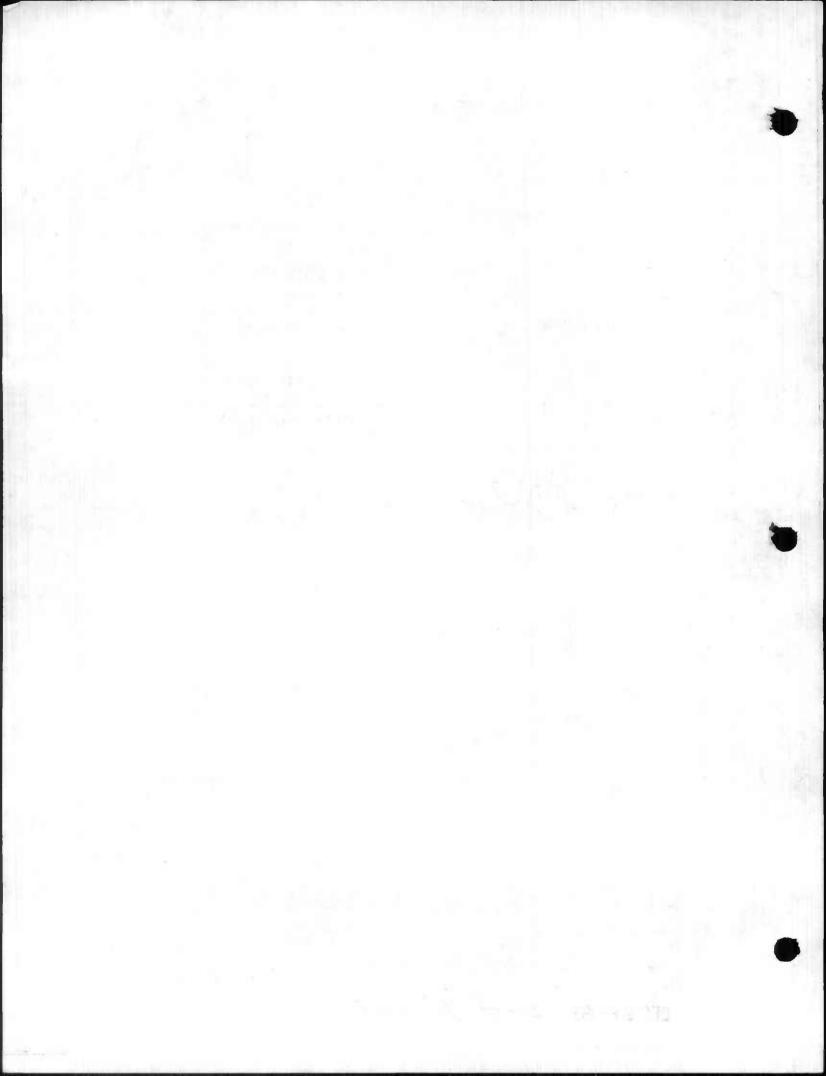
Registrar

31. Date filed (Month, Day, Year)

DEC 2 8 1999

Flizaheth

32. Registrar's Signature



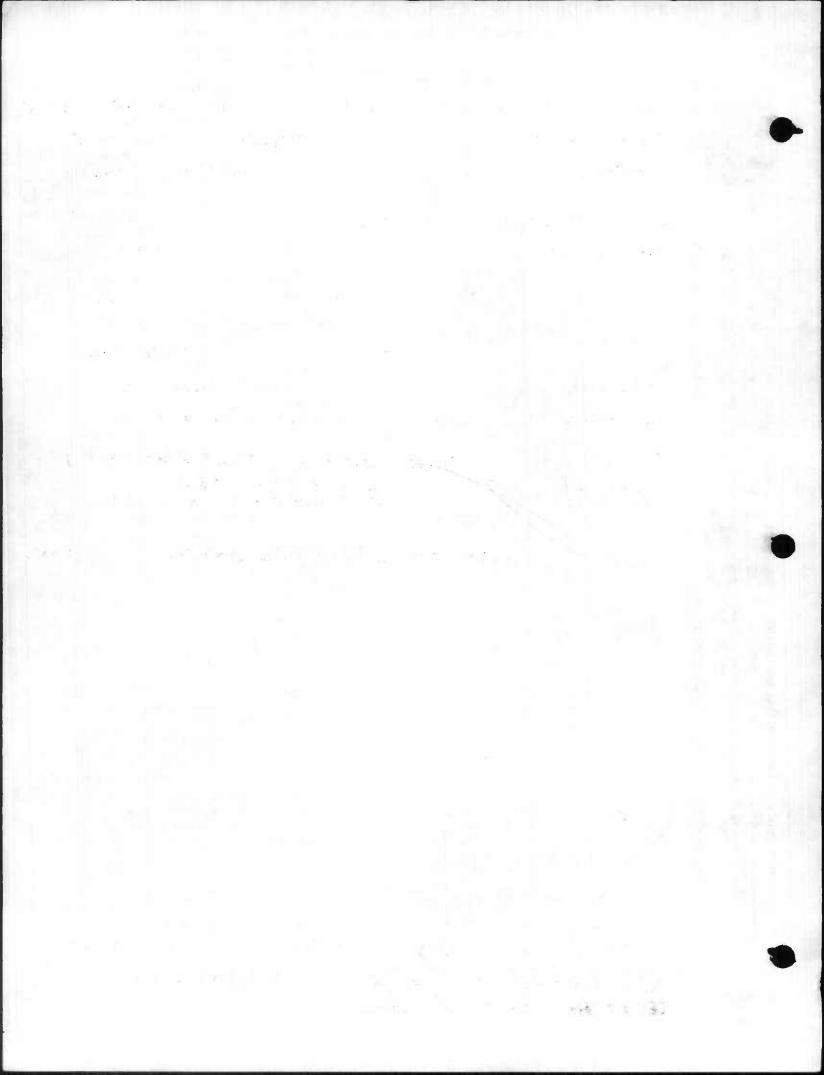
State of Maryland / Department of Health and Mental Hygiene Q Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1999 Deborah Butter Dec. 10:00 AM /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** 2 Klarking Court Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) June 1, 1942 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 M 2 VF 143-28-4109 57 Yrs. Delaware Director Usual Residence of Decedent with the Meryland permit. Peges 1 and 2 should be filed within 72 hours effer death with the Merylan Department of Health end Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23s or 28s-f show any fujury or other traumatic event, the Medical Examiner must be notified at ence. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director MD Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 Klarking Court 21403 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 4 Teacher Public Education 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Arthur Biloon Irene F. Biloon (Fisher) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Stephen Allan Butter - Husband 2 Klarking Court, Annapolis, MD 21403 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/27/99 Wilmington, DE Jewish Community Cem. 21. Signature of Funeral Seviend Conso 22. Name and Address of Facility
Schoenberg Memorial Chapel 519 Philadelphia Pike, Wilm., 23e. Part1. Enter the disease, or comshock, or heart failure. List only relations thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical tmmediate Cause (Finat diseese or condition resulting in death) ENDIMETRIAL LANGER Examiner Due to (or es a consequence of) Examiner g physicien and es the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequença of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical Due to (or es e consequença of) use ed by the a 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 200 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to Completed completion of cause of death? page 2 s hes 1 ☐ Yes 2 Z No 2000 certificate 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1º 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Menner of Deeth 28a. Dete of tnjury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury et Work? Certification: 5 Pending investigation 1 Netural 2 Accident s efter death. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) end menner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) within 2 To the F 29b. Signature and 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

RACE WD 900 BESTOATE RD #300 AWARDS WD 6 32. Registrer's Signature

DHMH 16 Rev 6/95

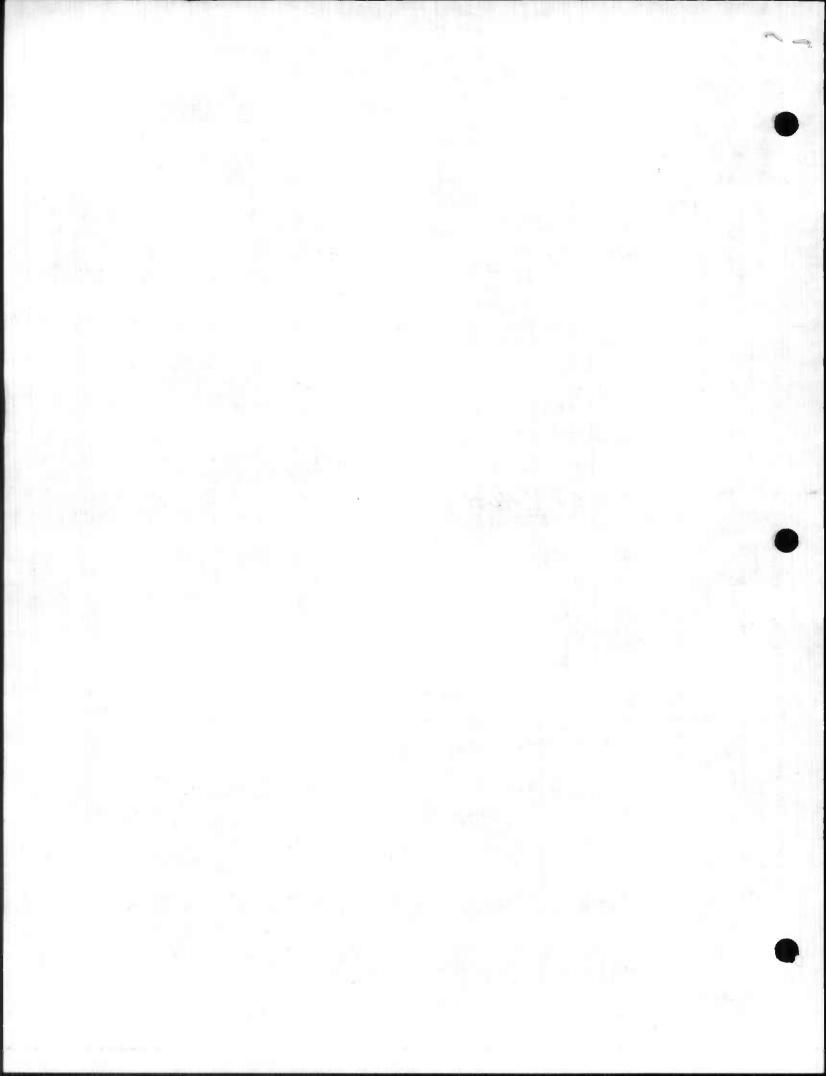
Registrar



State of Maryland / Department of Health and Mental Hygiene 99 1, 1981

							Ce	rtificate of	f Death		R	eg. No.			
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ā	/Medi				Cather	ine	Baer				Dec.		1999	1:30	P.M.
y	Examir		The second second		va street and numbe						ocation of Daath	4c. Count	y of Death		
L					ement Home			W Hadard Va	Willi				ningto		
	Funeral Director		5. Social Security N 218-50-3 Usual Rasidance of	3117	Sax 1□ M 2 A F	Aga (In yrs. le 88	Yrs.	if Undar 1 Yas Months Day		Min.	8. Data of Birth (Month, Day, NOV . 6,	Year) 1911	9. Birthp Cour Mary	piaca (State ntry) / land	a or Foreign
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Division		Certification:	4 Homicida	detarmined	building,	etc. (Specify)	ne, tarri, sti	eat, factory, office	ð		City or Town	, Steta)	Del Gi Muiz	II HODIE INC	imber,
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	To the Hos within 24 h To the Fun completely	N P	29b. Signatura and	Rogition	The state of the s	Nuioo.		29c. Lice	nsa number		2:	9d. Data sign	gd (Month,	Day, Year))
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			30. Nama and addre	ess of person was	mplated cause of	death (Item	23a) (Type,	Print) /	011-0		1 11	14	-1111		/
			STEPHE	NET	trzven	uns	71	() Wan	THEO	WA	IT HAG	GEAL (T	THUN	, the	6
	Sta	te	31. Data filed (Mont	th, Day, Year)	32. Regis	rar's Signatu	ira /g	100	11						
	Registr	ar		ECZ8 R	399	-	10.	japon	12/						





Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Month Year Physician December 23, 1999 0951 A Volena Cross /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) **Examiner** Union Hospital of Cecil County Cecil Elkton If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 TF 80 412-20-5763 Yrs. February 14,1919 Tennessee Director Usuel Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 25a-f show 1 ☐ Yes 2 No New Castle New Castle Delaware Director 10g. Citizen of What Country? 10a Street and Number 10f. Zin Code Norms 23a or munt be 19720 United States 260 Christiana Road, B-2 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. affer 1 ☐ Never Merried 2 Married Yes 2 No ð Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: 3 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 8 Homemaker In her own home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked other any Injury or other traumatic event 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Maudie Church Tull Franklin 19a Informent's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19720 260 Christiana Road, B-2, New Castle, Delaware Edward C. Cross, Sr./Husband 20b. Plece of Disposition (Name of 20a. Method of Disposition Date 20c, Location - City or Town, State cemetery, cremetory or other place) 1 Buriel 2 □ Cremation 3 □ Removal from State Gracelawn Memorial Park 12/27/99 New Castle, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Hicks Home for Funerals, P.A. 21. Signeture of Funeral Service Licensee ber 103 West Stockton St., Elkton, Maryland 21921 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Finel /Medical Cardiac Arrest 7 Days disease or condition resulting in death) Examiner Due to (or as e consequence of): Cerebral Vascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Chronic Atrial Fibrillation physician Box 68760 Physician/Medical 94 Due to (or es a consequence of): Coronary Artery Disease attending Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o 8 B 0 1 Yee 2 No 3 Probably 4 Unknown Essential Hypertension peudis Records, à 24b. Were autopsy findings aveilable prior to Chronic Renal Failure 24a. Wes an eutopsy performed? Completed completion of ceuse of death? page 2 Pneumothorax 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo To E S 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification:

27. Manner of Death

NEWatural 2 Accident 5 Pending 3 Suicide 4 Homicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the ceuse(s) and mennar as stated.

investigation 6 ☐ Could not be

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) end menner stated. 29c. License number

DC 2100

29d. Date signed (Month, Dey, Year) 1 December 24, 1999

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

ec ev THAD 34 Name end address of person who completed ceuse of death (Item 23a) (Type, Print)

John P. Mulligan, M.D. 223 West Main Street, Elkton, Maryland 21921

Registrar

Medical

29a, Certifier

(Check only

290/Signature and title of certifier

DEC 8 7 1999

32. Registrer's Signeture/

oouts!

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Ather

death.

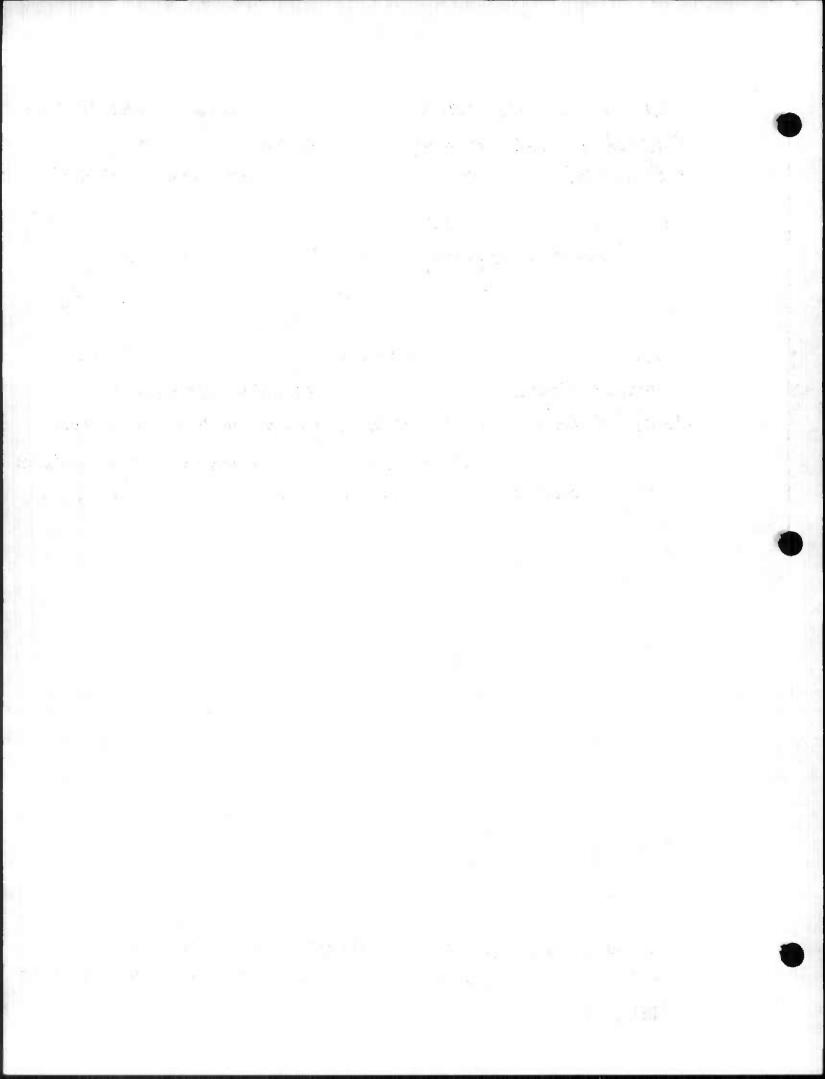
we Koepital or Attendi in 24 hours after death we Funeral Director: A pletely filled in by the f

To the To To the F

Division Attending

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland / Department of Health and Me Certificate of Death	_	giene Reg. No.	3 41984
	Physici /Medi			2. Date of De Month December	ath Day_	3. Time of Death Year 1999 06:00 AM
	Examir Funeral Director		4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Loc 883 W. Pu LAS Ki High WAY 5. Social Sacurity Number 6. Sax 7. Age (Id yrs. last birthday) Months Days Hours Min		4c. County Ce	
	death with the Meryland ms 23a or 28a-f show	ctor	10a. State 10b. County 10c. City, Town or Location MD CECIL ELXTON			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	23a or 28	Funeral Director	10e. Street and Number 10f. Zip Code 21921		10g. Citizen of W	
020	72 hours efter dea natural", or items	by	11. Marital Status 1 Never Marriad 2 Married 1 Never Marriad 2 Married 3 Widowed 4 Divorced 12. Was Deceded Ever In U,S. Armed Forces? 1 Never Marriad 2 Married 12. Was Deceded Ever In U,S. If Yes, specify Cuban, Mexican, Puarto Response of the Yes, Give Year or Datas:	cify Yes or No Rican, atc.)	14. Race Blac Specify	e - American Indian, k, White, etc : WH 1 Te
21215-0020	d within 72 hours piene. r than "natural", the Medical Ext	Completed	15. Decedent's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) DCALCR	9	16b. Kind of Bu	isinass/Industry Itiques
Maryland	2 should be filed v and Mental Hygie is marked other th reumatic event, th	To Be C	17. Fathar's Name (First, Middla, Last) 18. Mother's Name	dA C	Maiden Sumam Ameri	e) / 0 W
Baltimore, Ma	of Health item 27		WINEFIED Johns ton-Daughter 14 Prescott Dave 20a. Mathod of Disposition 1 Burial 2 Programation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)		AIK De.	(19702 City or Town, Stata
Balti	Memit. Page Important: If Important: If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eclurary MINICKearn 6 ce Funeral Ho	me 2	59 E. 1.	MAIN STELLTON
	Physician /Medical Examiner	er.	23a. Part 1. Entar tha disaase, or amplications that caused the death. Do not entar tha mode of dying, such as cardlac or shock, or heart fallura. List may on cause on each line. Immediata Causa (Final disease or condition rasulting in death) a. Culvitary hung mg 55 Due to (or as a consequence of):	respiratory at	rest,	Approximate Interval Between Onset and Death
Box 68760,	certificate be executed nding physicien end use es the burial-transit	n/Medical Examiner	Sequentially list conditions, if any, laading to immediata causa. Enter Inderlying Cause (Disease or injury that initiated events rasulting in death) Last b			
P.O. B	es that the death certific igned by the attending p be detached for use es	by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			ntribute to the cause of death?
Records, P	requir been s should	Completed by P	alzheimens dementis	24a. Was	vee 2 No an autopsy med?	3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of causa of death?
	The ate h		25. Was case referred to medical 26. Place of Death	101		1 □ Yas → □ No
ion of Vital	£ 5 m	ation: To Be	examiner? 1 Yes 2 No	na 5 Resid		1 1 11
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	4 Homicide building, atc. (Specify)	City or Tov	vn, State)	er or Rural Route Number,
	the Hose ithin 24 ht of the Fundamental properties of the Fundamen	Medical	29a. Cartifiar (Check only one) 29b. Signature and titla of out fine 1 ★ Certifying Physician: To tha bast of my knowledge, daeth occurred at tha time, date and place, and manner stated. 29b. License number	d at the time,	data and place, a	and dua to the causa(s)
•	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	>	Dec, 2	7, 1999
	Sta	te	31. Data filed (Month, Day, Year) 32. Ragistrar's Signature	Ave-	Lecil	yon, ma. 21713
	Registr		DEC 2 7 1999 Serve & Son V.			



Year

3. Time of Death

2:10am

George's

irthplaca (Stete or Foreign

10d. Inside City Limits 1 Yes 2 No

21635

Approximata Intervel Batween Onset and Daeth

Chester, MD.

Reg. No.

2. Date of Death

Month

Galena Funeral Home of Stephen Schaech

Galena, MD.

State of Maryland / Department of Health and Mental	Hygiene
Certificate of Death	Reg No.

	Physic /Medi Exami	ical
	uneral irector	
th the Maryland	or 28a-f show	lirector .

7 is marked other than "natural", or itema 23a treumatic event, the Medical Examinar must be

permit. Pagas 1 and 2 should be filed Department of Health end Mental Hygis Important: If item 27 is marked other any Injury or other treumatic event. It

filed within 72 hours after

Baitimore, Maryland 21215-0020

Funeral

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Be Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

edical

JAMES	WESL	EY CHAI	RES	SR						DEC.	26, 19	999	2:10
4e Facility Neme	(If not institution	n, give street end n	umber)					4b. City, To	own, or L	ocation of Deat	4c. Count	y of Dea	th
4903	Sundow	n Rd.						Bow	rie		Prin	nce	George
5. Social Security 217-01-		6. Sex 1 XLM 2 ☐ F	7. Age	(In yrs. last b	oirthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da MAY 1		1	thplaca (State or Fountry) ryland
Usual Residence													
10a. Stete	10b. County	,		10c. City, To	wn or Lo	cation							10d. Inside City
MD	Ken	t	-	Ches	ter	town							1 X Yes 2
10e. Street and N	Number					10f. Zip	Code				10g. Citizen of	What Co	ountry?
208 H	eron F	oint					216	20			U.S.A		
11. Meritel Stetus 1 Never Married ZM Merried 3 Widowed 4 Divorced 12. Wes Decedent Ev. Armed Forces? 1 Yes ZM No If Yas, Give Yaar or Dates:				13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes ②② No Specify:					14. Race - Amarican Indian, Bleck, White, etc. Specify: White				
(Sp	15. Deceder	nt's Education est grade complated)	16	(Give	lent's Usu kind of wo	rk done	during mos	st of worl	king	16b. Kind of E	Business	Andustry
Elamantary/Se	econdary (0-12)	College	(1-4or 5-	+)		o woru perv				ega il	C & P	Те	lephone
17. Fathar's Nam	chaire	•								e (First, Middle) Virgin			
Norma	J. Cha	ship (Type, Print) Aires (wif	e) 2	08	Hero	n F		er or Ru	ral Route Numb hester	er, City or Town	MD.	Zip Code) 21620
20e. Method of D		2 Demonstran	Chata	20b. Place cemet		sition (Name		109)		Date	20c. Location	- City or	Town, Stete

Physician /Medical **Examiner**

physician and the burial-transit

98 usa for

the signed by to

peen has page 2

cartificata

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartific

Box 68760.

Division of Vital Records, P.O.

requires that the death cartificate be

Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest

Immediate Cause (Final

disease or condition resulting In death)

1 ☐ Burlal 2 Cramation 3 ☐ Removel from State

4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Sepvice Licanses

1. Decedent's Nama (First, Middla, Last)

Coronary Artery Disease Due to (or as a consequence of):

isease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, fure. List only one cause on each line.

Chesapeake Cremation 12/29/99

118 West Cross St.

22. Name end Address of Facility

Dua to (or es a consequence of): Due to (or as e consequence of):

M00510

Pert II.	Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

24b. Wara autopsy findings sveilable prior to completion of cause of death?

1 ☐ Yas 2 🕅 No 26. Place of Death (Check only one)

1 ☐ Yas 2 ☐ No

25. Was casa raferred to medical 1 Yas 21 No 27. Menner of Deeth

1 Neturel

2 Accident

4 Homicida

3 Suicide

29e. Cartifiar (Check only one)

1 Inpatiant 28a. Dete of Injury (Month, Dey Year)

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury et Work? 1 Yes 2 No

Other: 4 Nursing Homa 5 TResidence 6 Other (Specify) 28d. Describe how injury occurred

6 Could not be detarmined 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

TC Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end menner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29b. Signature and title of carrifier

5 Pending

invastigetion

29c. License number D0053250 29d. Date signed (Month, Day, Year)

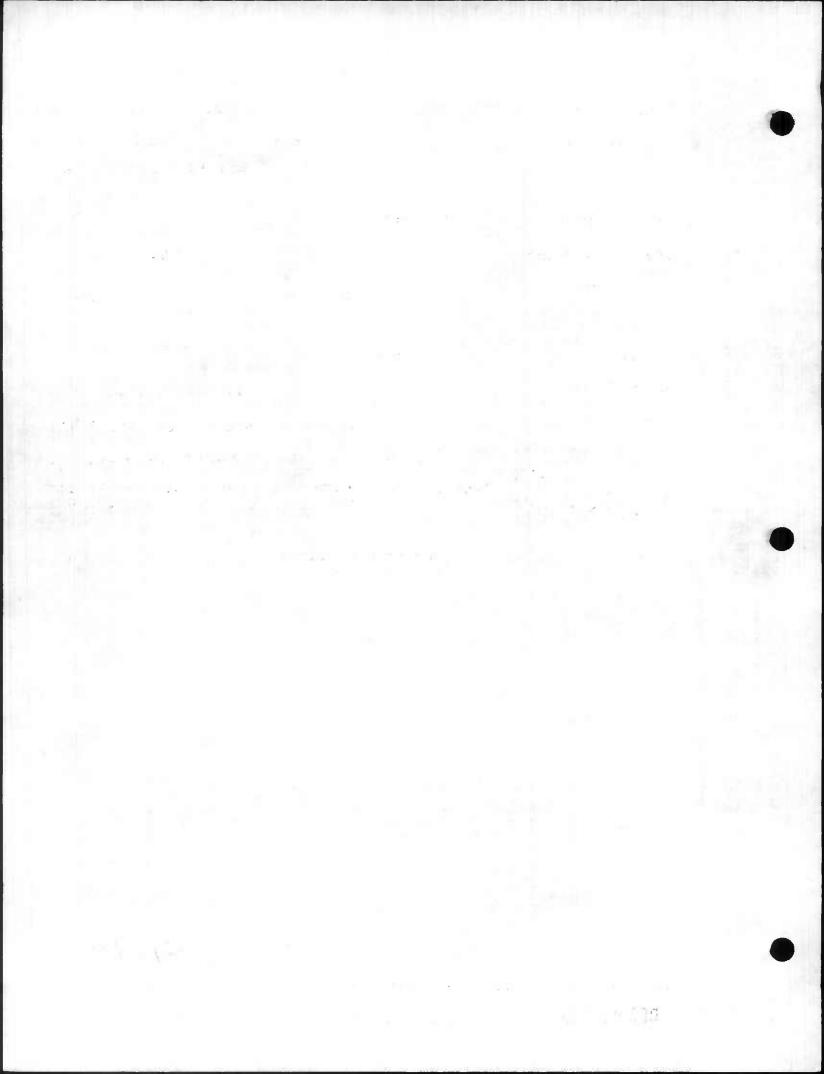
30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

Chestertown, MD. 21620 100 Brown St. George Panas, M.D.

31. Dete filed (Month, Dey, Year) DEC 2 8 1999

32. Registrer's Signeture

State Registrar



Joseph Charpentier

	State of Maryland / Department of Health and M Certificate of Death	lental Hygier	2	1986
Dhusisian	Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year	3. Time of Death
Physician /Medical	UUSEDA DUNATU GAATDENLIEF		29,1999	4:45 AM
Examiner		ocation of Death	4c. County of Death	
7.4	Civista Medical Center La Plata 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	O Date of Dish	Charles	
Funeral Director	040 20 7726 1X M 2 F 72 Y Months Days Hours Min.	(Month, Day, Ye	1927 Mas	place (State or Foreign intry) Sachusetts
puel Maria	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Men Tor	Maryland Charles Waldorf			1 ☐ Yes 2 No
h with the Menyler (3a or 28a-f show at be notified at	10e. Street and Number 10f. Zip Code 20602	10g.	Citizen of What Cou USA	intry?
aryiand 21215-0020 should be filed within 72 hours after death with the Meryland and Mental Pyglene. I marked other than "natural", or items 23a or 28-4 ahow urmatic event, the Medical Examples multiple motified at To Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced Year or Detes: 1947-67 1☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Wh	, etc.
Baitimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours att reportant of Health and Mental hygiene. reportant: if item 27 is marked other than "natural; or my injury or other traumatic event, the Medical Examinate.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Climatologist	ing 16b.	. Kind of Business/Ir Weather	ndustry
d High	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Maid		
yian yian weld be Mental write ev	Diomede Charpentier Beatrice	J. Cresge	9	
Aary 2 shot and N Is me	19a. Informant's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural)	al Route Number, Cit	y or Town, State, Zi	p Code)
and and marth	Robert J. Charpentier-Son 12 Swannee Court, Ashl			
Baitimore, Maryland 212' permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Mance. To Be Comp	20e. Method of Disposition 1XD Burial 2 Comments 3 Removal from State 4 Done for 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens 1.	-3-00 Wa	Location - City or T Idorf, MD	own, State
Bait permit. Depart Importu	21. Signature of Funeral Service Louises August 22. Name and Address of Facility Huntt Funeral Home Mark G. Brohawn M00053 P. 0. Box 156, Wale	dorf, MD 2	20604-015	6
	23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac cannot shock, or heart failure. List only one cause on each line.	or respiratory errest,		Approximate Interval Between Onset and Death
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	line	1	KZWK2)
executed on and rial-transit Examiner	Due to (or as a consequence of):			16mo
58760, cate be executed physicien and s the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of):	elevis		xyw.
Box 68 seth certifical attending plans as a for use as clan/Mec	d			
Is, P.O. Box 6 es that the death certific igned by the attending be detached for use as by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		2 No 3 Pro	to the cause of death?
cord requir been s should		24a. Was an au performed	? 8	Vere eutopsy findings vailable prior to ompletion of cause f death?
i Re lav		1□ Yes	20 No 1	Yes 2 No
f Vitai Rystelan: The last certificate hydirector, page	25. Was case referred to medical argument 26. Place of Death	(Check only one)	*	
Hyd Sid	1 ☐ Yes 20 No Hospital: 12 Hopatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Hot	me 5 Residence		ily)
On O	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 28a. Date of Injury 28b. Time of Injury Work? 28b. Time of Injury Work? 1 Yes 2 No	28d. Describe how in	njury occurred	
Division of Vita tal or Attending Physician: as after death: as after death: all Director: After this centification; ted in by the funeral director, Certification: To Be C	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)	28f. Location (Street City or Town, St		ral Route Number,
Division withing thours after death withing thours after death completely filled in by the filled in by the filled in Certificati	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and manner stated. Check only one)	and due to the cause ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within to the company of the the company of the the company of the company	29b. Signeture and title of cartifier 29c. License number D-20629	29d.	Date signed (Month)	Day, Year)
	30. Name and address of person who completed cause of deeth (Item 23a) Type. Fint) George H. Wathen, MD. 11345 Pembrooke Square, Suite 103	, Waldorf	, Marylan	d 20603
State Registrar	31. Dete filed (Month, Day, Year) DEC 3 0 1999 32. Registrar's Signeture 6. Aparlor			
	31. Dete filed (Month, Day, Year) 32. Registrar's Signeture	, waluull	, narytan	u 20

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- DEC 1 0 1190 June

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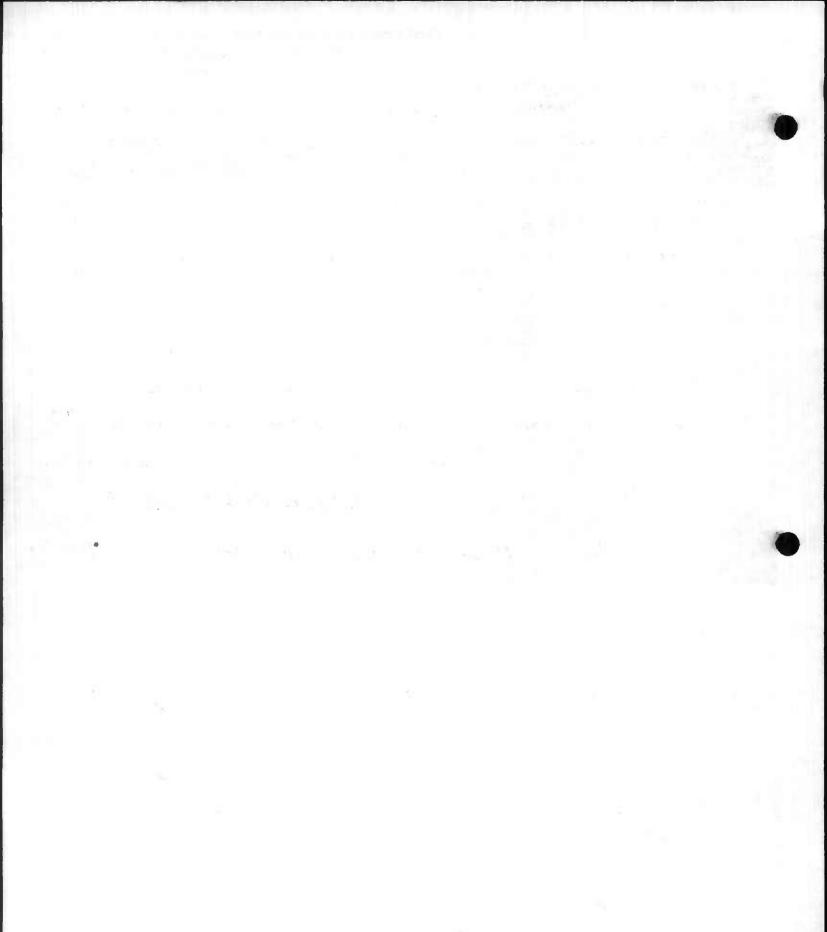
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Van Edwards 9:20 pm Maude Caudil1 Dec 1999 23 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 207 Maple Ave., Apt. 5B Greensboro Caroline If Under 1 Year | If Under 24 Hrs. | S. Dale of Birth (Month, Day, Hours Min. Sept 6 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F 95 Mary Land 217-09-8831 Yrs Director Usual Residence of Decedent with the Marylend 10b. County 10c. City, Town or Location 10a. State 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumstic event, the Medical Examinar must be notitled at 1 X Yes 2 ☐ No Director Maryland Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours after death v Department of Health and Mentel Hygiena. Important: If item 27 is marked other than "natural", or items 23a eny injury or other traumatic event, the Medical Example means 207 Maple Ave., Apt 5B 21639 U.S.A Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, Black, White, etc. 1 ☐ Yes 2 🕱 No if Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) 5th homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be William Edwards Anna Baynard Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Ralationship (Type, Print) great 7149 Milford Harrington Highway, Harrington, Lynda L. Turner Wyatt/ 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery 12/27 Greensboro, Maryland 21. Signatura of Funeral Service Licensee 22. Name and Addrass of Facility Fleegle & Helfenbein Funeral Home, PA

23a. Partl. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest,

25a. Partl. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, Approximata Interval Between Onsel and Death Physician /Medical immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the Due to (or as a consequence of) 80 950 for Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to Completed completion of cause of death? has 1 ☐ Yes 2 MNo 1 ☐ Yes 2 ☐ No certificate funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residance 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 28c. injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident or Attend efter death Director: 6 Could not be datarminad 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours elemental D 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as statad.

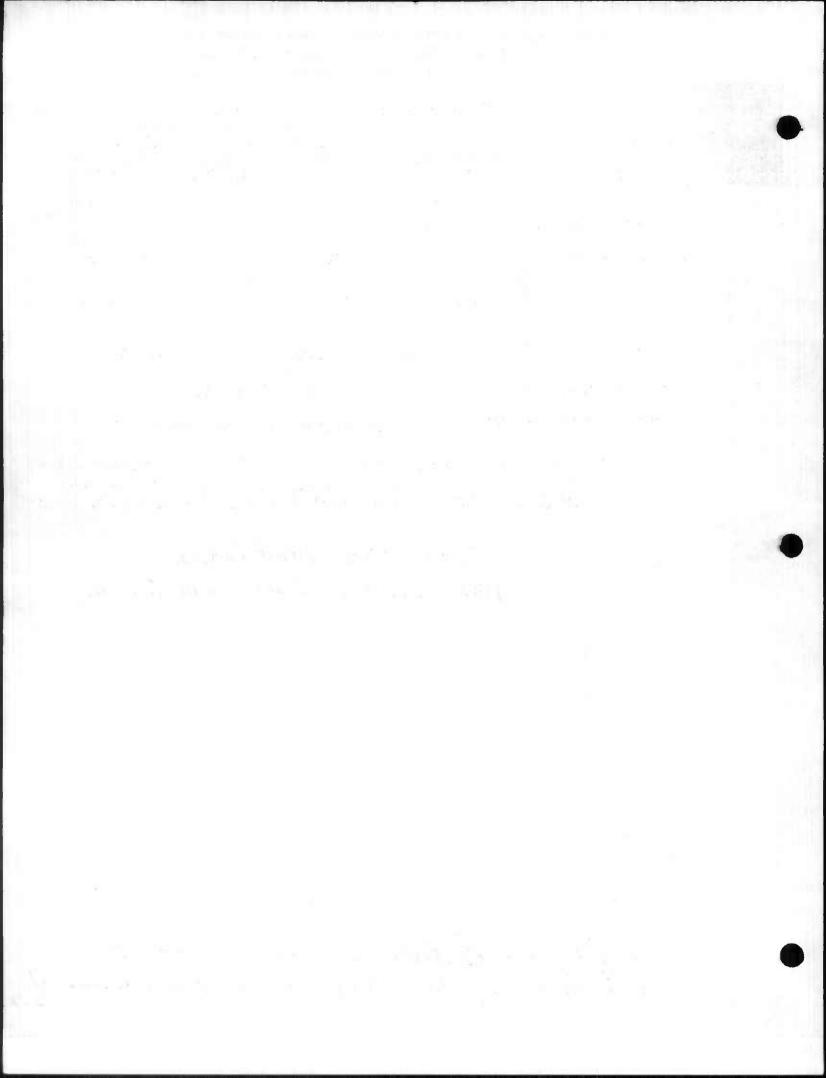
2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to tha cause(s) and mannar stated. 29a. Certifian Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Nama and address of person who completed cause ot daath (item 23a) (Type, Print) David H Smith 509 Idlewild Ave Easton, Maryland 21601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Charles Harold Cunningham December 25, 1999 3:00am /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6146 Regent Park Rd Catonsville Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 Indiana 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days 1⊠M 2□ F Yrs. 050-07-7727 87 Director Usual Residence of Decedent filed within 72 hours efter death with the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Baltimore Catonsville 10e. Streef and Number 10g. Citizen of What Country? 6 238 6146 Regent Park Road 21228 United States Funeral 12. Was Decedent Ever In U,S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 1942-45 Items Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married 21215-0020 "natural", or 1 Yes 2 No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Building Engineer Retail Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is tranked other any Injury or other traumatic event 90ce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Carl Andrew Cunningham Mary Ellen MacCleod 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Charles A. Cunningham/Son 2235 Frizzellburg Rd Westminster, MD 21158 Saltimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 Donation 5 Dother (Specify) entombment Memorial Park Cemetery 12-29-99 St. Petersburg, FL 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. (0 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete interval Between Physician /Medicai Immediate Cause (Final disease or condition resulting in deeth) Examiner Curlinusular Nisease Examiner or Attending Physician: The law requires that the death certificete be executed buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last end Due to (or as a consequence of) Box 68760 physician Physician/Medical Due to (or as a consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed by 24b. Were autopsy findings available prior to completion of causa of death? 24a. Wes en eutopsy performed? this certificate 28 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 ☐ Nursing Home 5 💆 Residence 8 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Menner of Death 28a. Date of Injury (Month, Dey Yeer) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of After 5 Pending Investigation 1 Netural efter death. 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 Homlcide 24 hours Hospital 29a. Certifier (Check only one) 🖄 Certifying Phyalcian: To the best of my knowledge, death occurred af fhe time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 121512 December 25, 1999 10 30. Name and completed cause of deeth (Item 23a) (Type, Print) Wilhers Avenue Butimor, Mily 06 32. Registra/s Signature 2023 31. Date filed (Month, Dey, Year) State נבכו Registrar

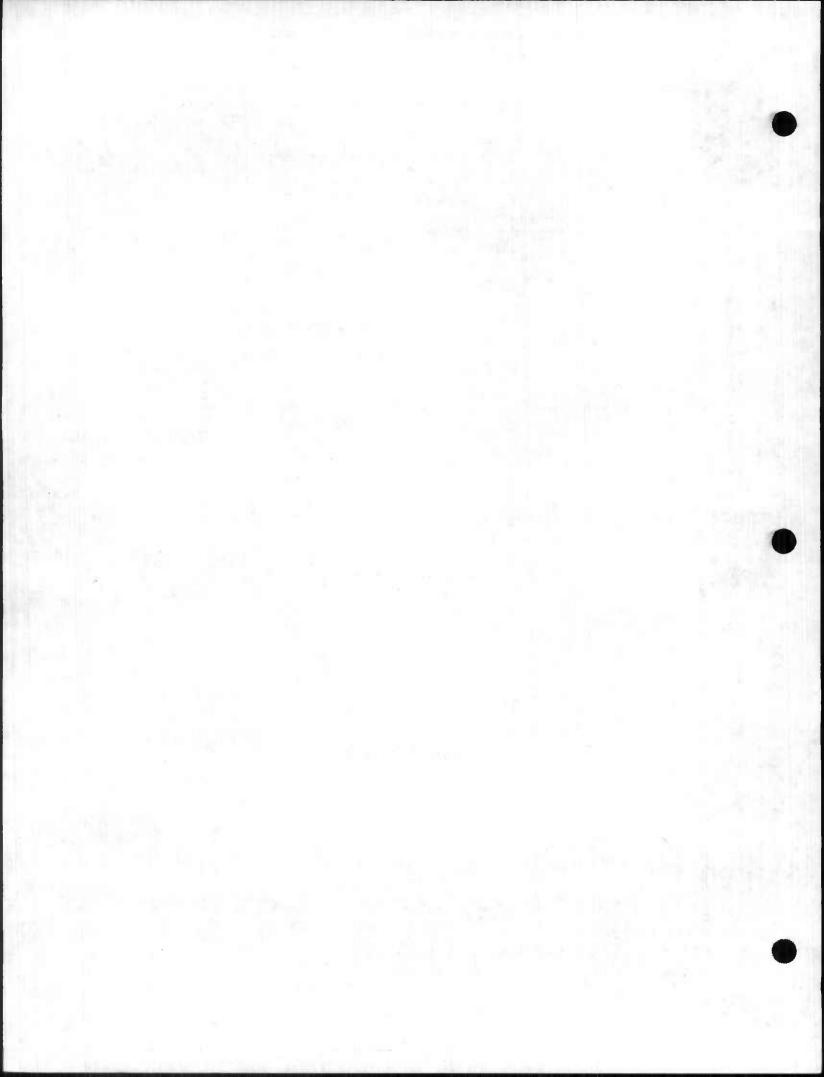


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State of Maryland / Department of Health and Mental Hygiene 99 4 1989

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Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 990 Amended #31,12/28/99,PCT, Howard Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) December 27, 1999 **Physician** Gladys Dowell Cook 4:50 am /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street end number) 4c. County of Deeth **Examiner** Heart Home Pasadena Anne Arundel 5. Sociel Security Number if Under 1 Year If Under 24 Hrs. Birthplece (Stele or Foreign Country) 7. Age (In vrs. lest birthdev) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1□M 2X F Yrs Director 170-18-8049 Feb 13, 1914 Pennsylvania Usuel Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumetic event, the Medical Examinar must be notified at 1 No Yes 2 No Directo MD Anne Arundel Pasadena 10e Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country? 8016 Ritchie Highway 21122 USA Department of Haath and Alental Hygiene.

Throctant: If tem 27 is marked other than "naturel", or items 23a my Injury or other traumatic avant Funerai 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indien 11. Marltal Status Bleck, White, atc. 1 ☐ Yas 2 ☒No It Yes, Give Yeer or Datas: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: þ 3 XWidowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) College (1-4or 5+) Draftsman Westinghouse 2 years 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) August Paetzel Emma Kelly 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 20b. Plece of Disposition (Neme of cemetery, crematory or other place)

20b. Plece of Disposition (Neme of cemetery, crematory or other place)

20c. Location - City or Town, Stete Sharon Morell /daughter 20e. Method of Disposition 1 Suriei 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 12/29/99 Burtonsville, Maryland Union Cemetery 22. Name end Address of Fecility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707–4389

Approximate poly one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** CORUMNY - HUPERITUSION, CAD /Medical Immediete Ceuse (Fine) disease or condition resulting in daath) Examiner Dua to (or es e consequence of):

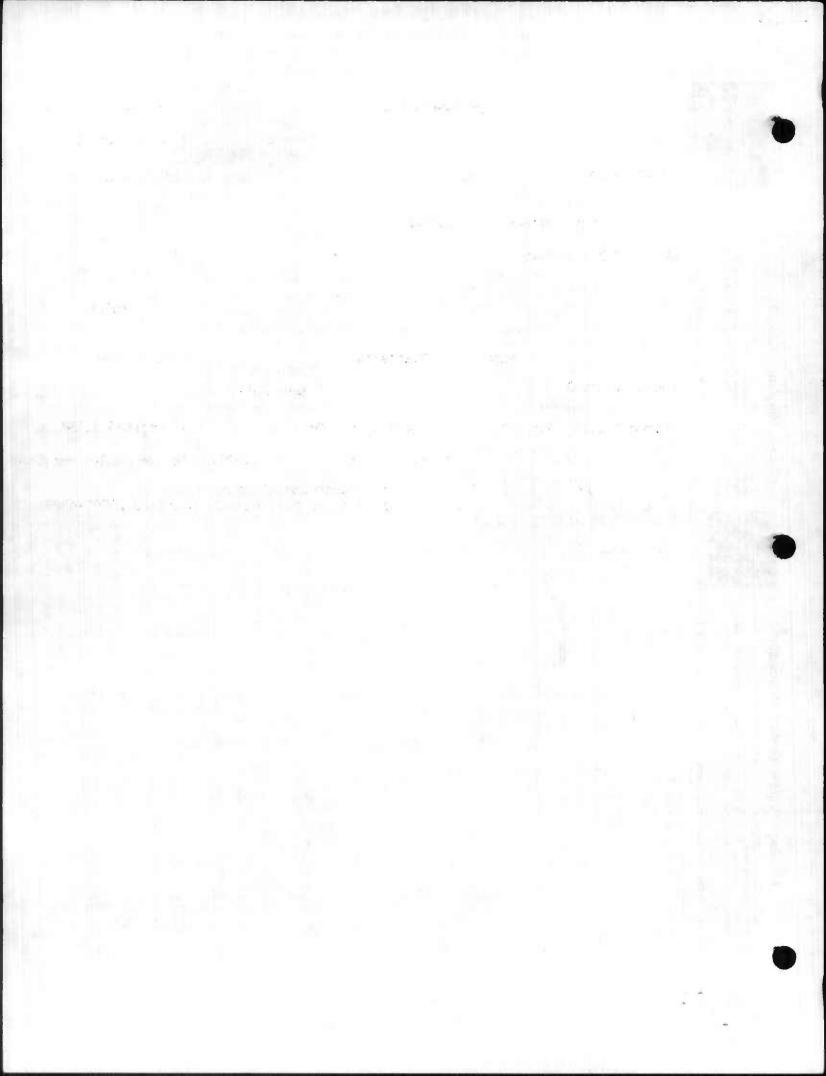
TRUST RECURE CORUMO STERVISIS Examiner attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Dua to (or es e consequence ot) death certificate be axec P.O. Box 68760. Ancula Physician/Medical Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? spendules trole una 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, by 24b. Ware eutopsy tindings eveilable prior to completion of cause of daeth? 24e. Was en autopsy performed? Rearand Sungery Treatend family Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physicien: funeral director, 25. Was casa reterrad to medical exeminer? 26. Placa of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28e. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Lund 27. Manner of Deeth 28b. Time ot 28c. Injury et Work? 1 ONeturel 5 Pending 1 Yas 2 1No 24 hours after death.

Funerei Director: A 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 🗠 Certifying Physician: To tha best ot my knowledga, daeth occurred et the time, dete end plece, and dua to the ceuse(s) end mennar es stated. edicai completaly (Check only one) 2 Medical Examiner: On the besis of examination and/or investigetion, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and menner stated. within 2 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number

Registrar

31. Dete tiled (Month, Dey, Year) 32. Registrer's Signeture DEC 2 8 1999 >

mison who completed cause of death (Item 23s) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Time of Death Month **Physician** 27,1999 0255 Dec. Nancy Hollingsworth Carter /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot Easton Memorial Hospital Easton If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthpleca (State or Foreign Country) **Funeral** Days 1 M 2 XF Yrs. Director 225-52-6163 59 Dec. 27, 1949 Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d Inside City Limits Caroline Maryland Preston 1 ☐ Yes 2 No Director 238-1 10f. Zio Code 10g. Citizen of What Country? 10e, Street and Number b 21655 Numer 23s 22926 Lyn Oaks Dr. U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. "natural", or Itam adical Examiner Hed within 72 hours after Hygiene. ther then "netural", or its 1 ☐ Never Married 2 🗓 Merried 1 Yes 2 No Specify: If Yas, Give Year or Detes: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working tifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Director Hospital-Health 18. Mother's Nama (First, Middle, Maiden Sumeme) 17. Fathar's Neme (First, Middla, Last) 89 Pages 1 and 2 should be named of Health and Mental Roy O. Williamson Jeanette Wetzel 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurat Route Number, City or Town, State, Zip Code) important: If item 27 is any injury or other tran James M. Carter/Husband 22926 Lyn Oaks Dr., Preston, MD 21655 Baltimore, 20b. Place of Disposition (Name of cematary, cremetory or other place) 20a. Mathod of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Cambridge Crematory 12-27 | Cambridge, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Curran-Bromwell Funeral Home, P.A. muell 308 High St., Cambridge, MD 21613 lease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and that only one cause of each line. Approximata Interval Batween Onset and Death Physician /Medical Immediata Cause (Finel disease or condition resulting in death) Varian Smonths Examiner Dua to (or as a consequence of) Examiner physician and the burial-transit that the death certificate be executed Sequentially list conditions, if any, laading to immadiate cause. Enter Undarlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? PO signed by 3 Probably 4 Unknown 1 ☐ Yes 2 No Small Olistruction Bornel Division of Vital Records. by The law requires 24b. Were eutopsy findings aveilable prior to Completed 24a. Wes an eutopsy completion of cause of deeth? page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 Yes 2 No To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, term, street, factory, office building, atc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and dua to the ceuse(s) and menner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of cartifier 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

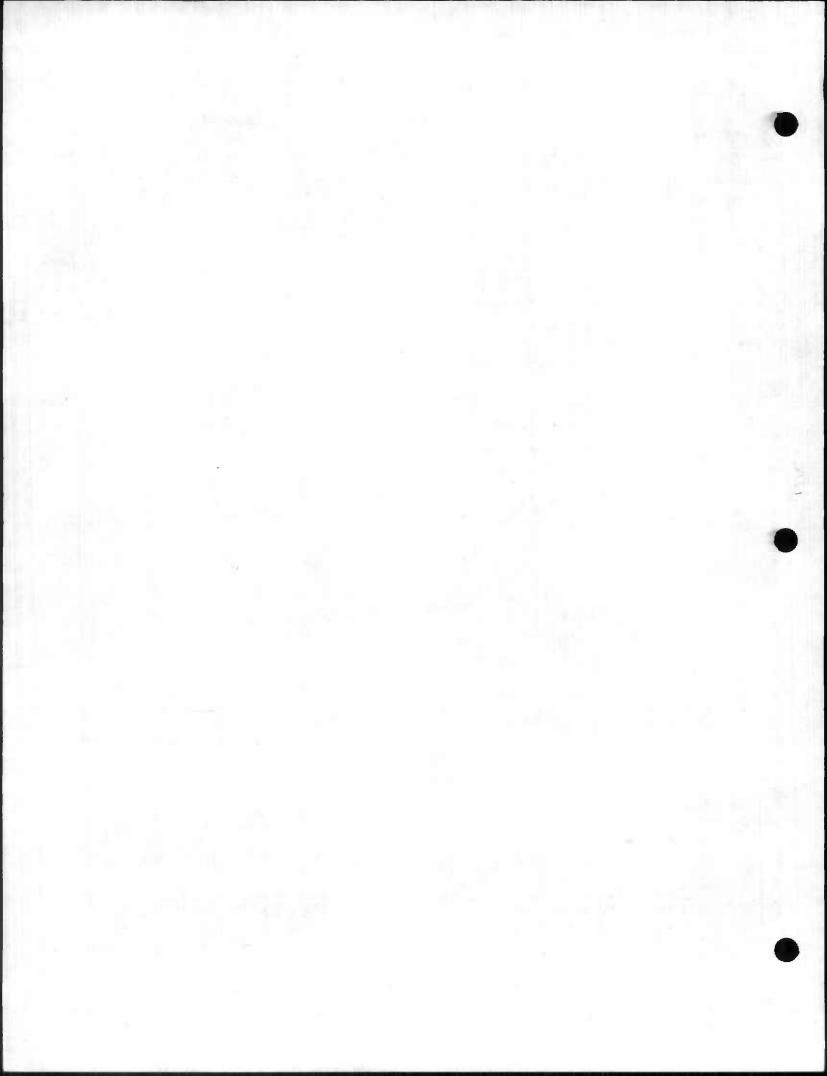
State Registrar Mary De Shields,

31. Dete filed (Month, Day, Year)
DEC 2 8 1999

Nancy Carter

32. Registrar's Signatura

M.D., 219 South Washington St., Easton, MD 21601



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

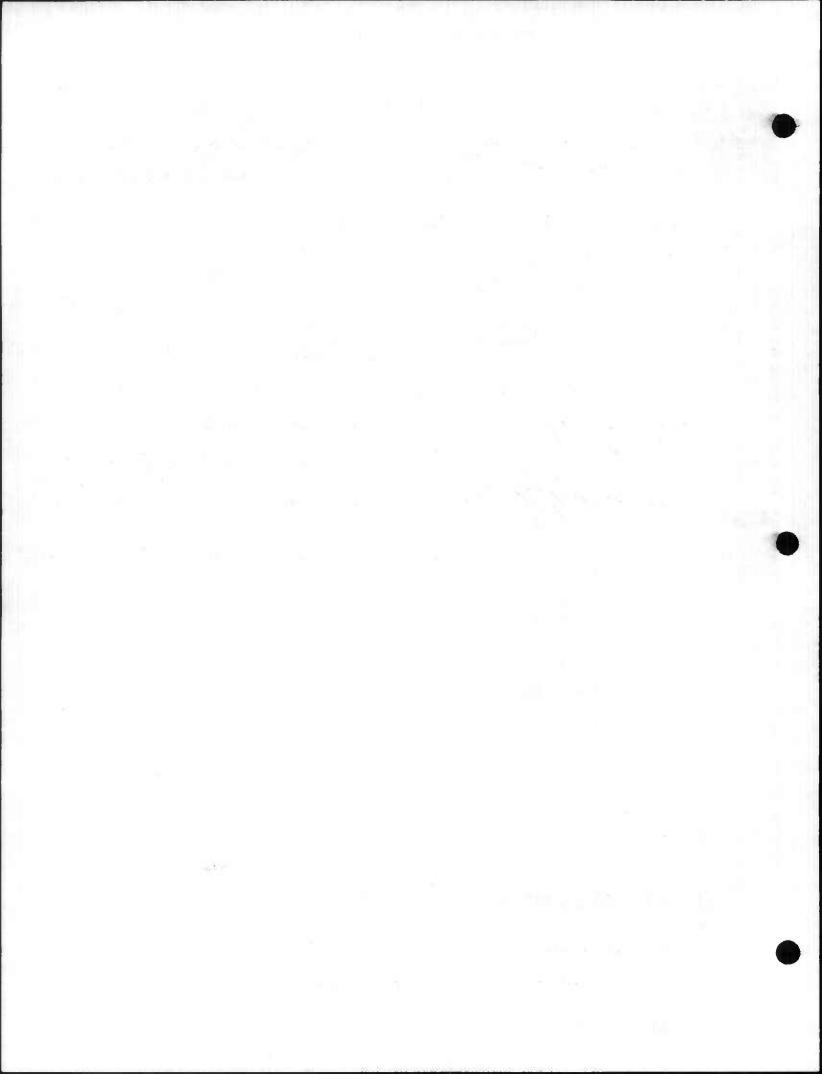
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day William G. Dolbow, Sr. 23, /Medical December 1999 7:15 AM 4s Facility Neme (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 228 Johnson Road Conowingo 8. Date of Birth (Month, Day, Year) 9. Birth Country)
April 27, 1917 New Jersey 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 M 2 F Days Hours Director 146-05-0888 82 Usual Residence of Decedent with the Manyland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "natural", or items 23a or 28a-f show shi hjury or other traumade event, the Madical Examiner must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maruland 1 ☐ Yes 2 No Cecil Conowingo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 228 Johnson Rd. Funeral 21918 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supervisor DuPont Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Jane Dolbow Francie Dilks 19a. Informant's Neme/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Alice Dolbow/Wife 228 Johnson Rd., Conowingo, MD 21918 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 🛱 Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Lawnside Cemetery 12-27-99 Pilesgrove, NJ 22. Name and Address of Facility R. T. Foard Funeral Home, P. A. re 111 S. Queen St., Rising Sun, MD 21911 000 ickard-Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical 2 months Examiner Due to (or as a consequence of) Examiner as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last pue Due to (or as a consequence of) attending physician Box 68760. the death certificate be Physician/Medical Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 100 COPD 3 Probably 4 Unknown 1 Yes 2 No signed by Records, À 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed has 1□ Yes 200No 1 ☐ Yes 2 ☐ No Division of Vital 26. Place of Deeth (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27, Manner of Death 28b. Time of 28c. Injury at Work? Certification: or Attending P star deeth. Director: After t 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier edical 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier De cember 23, 1999 Mas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Chosepeake Hospics, Elkton 10/Thern 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** DECEMBER 22 /Medical 4a. Fecility Name (If not institution, give street and number 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HO51 Cecil UNION ELKTON
If Under 24 Hrs. 8, D MD 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 222-05-964 89 Yrs Director Usual Residence of Decadent Peges 1 end 2 should be filed within 72 hours after death with the Maryland nent of Heelth end Mental Hygiene. not of Hems 23s or 28s-f show nt; if item 27 is marked other than "natural", or items 23s or 28s-f show 10e State 10c. City, Town or Location 10b Counts 10d. Inside City Limits ral", or items 23a or 28a-f ahow Examiner main be notified at 10WNSEND 1 Pres 2 □ No Completed by Funeral Director DelAWARE NEWCASTLE 10e. Street and Number 10g. Citizen of What Country? LISIA Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Btack, White, etc. 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2□ No WHITE 3 ☐ Widowed 4 ☐ Divorced 18a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State of Del Elementary/Secondary (0-12) Cottege (1-4or 5+) MECHANIC 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) SCWALD 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Town, Stete, Zip Code) N918 TOWNSEND Del. other t 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State = 8 permit. Pege Department of important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21115 Leown 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical Abdominal Aastic Anewrysm 12 Hours Examiner Due to (or es e consequence of) Physician/Medical Examiner The law requires that the death certificete be executed Sequentially tist conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Box 68760. Due to (or es e consequence of): P.O. Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 1 Unknown Division of Vital Records. þ 24b. Were autopsy findings eveilable prior to completion of cause of death? Completed 24e. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medicat examiner? Certification: To Be 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 MER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of tnjury (Month, Day Year) 27. Manner of Deeth 28d. Describe how injury occurred 28c. tnjury et Work? 1 Naturat 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident efter death Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Ptace of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral D Hospital 1 Certifying Phystolen: To the best of my knowledge, death occurred at the time, dete end plece, and due to the cause(s) end menner es stated.

2 Medicat Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) end manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Monte Mahous, MD 0-44783 December 22, 1999 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) 10 III WEST High STREET, ELKTON, MO 21921 MONTE MAKOUS MO 31. Date fited (Month, Day, Year)

32. Registrer's Signeture

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth ^{Dey}27 **Physician** Connie DeCaro December 9:40am /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Ellicott City 9966 Oak Lea Circle Howard 5. Sociei Security Number 7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer Birthplece (State or Foreign Country)
 New York **Funeral** Deys 1□M 2XF Months Hours Yrs 16, 088-16-8881 Director Nov Usual Residence of Decedent filed within 72 hours after death with the Maryland 10e. Stete 10b. County 10c. City, Town or Location 10d, inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Howard Ellicott City 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code ŏ 4644 Willow Grove Drive 21042 United States Items 23a Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Rece - American Indian Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 21215-0020 ò 1 ☐ Yes 2X No Specify: Specify Completed by 3X Widowed 4 □ Divorced White Year or Detes "natural", 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Clothing Peges 1 and 2 should be filed within nent of Haelth and Mental Hygiane. int: If Item 27 Is marked other than " irry or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Manufacturing Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Onofrio Toronto Nancy Famularo 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4644 Willow Grove Drive Ellicott City, MD 21042 Richard DeCaro/Son 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☑ Buriai 2 ☐ Cremetion 3 ☑ Removei from Stete Department of Important: If any injury or once. 4 ☐ Donetion 5 ☐ Other (Specify) 12-30-99 Riverhead, NY Calverton National Cem. 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth Physician /Medical Immediate Ceuse (Finel Renal disease or condition resulting in death) Examiner The law requires that the death cartificate be axecuted burial-tran Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or es e consequence of): Cardiniascular diseaso P.O. Box 68760, tensive Physician/Medical the Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 2 100 3 Probably 4 Unknown yd bengis Records, þ should be 24b. Were eutopsy findings evalleble prior to Completed 24e. Wes en eutopsy performed? completion of ceuse of deeth? page 2 25 No cartificata 1 Yes 1 ☐ Yes 2 ☐ No of Vital al or Attending Physician: Ts eftar daeth. funaral diractor, 25. Wes case referred to medical Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Death 28b Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Dev Yeer) 28c. Injury at Work? Division Netural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, ferm, street, factory, offica building, etc. (Specify) In by 4 - Homicide Pelli • Funeral Hospital Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner es steted.

2 Medical Examinar: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only one) completely To the Vithin 2 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number 5 30. Name and address of pay mpleted cause of deeth (Item 23e) (Type, Print) Columbia, MID 21044 Suite 210, atuxent Pkwn

DHMH 16 Rev 6/95

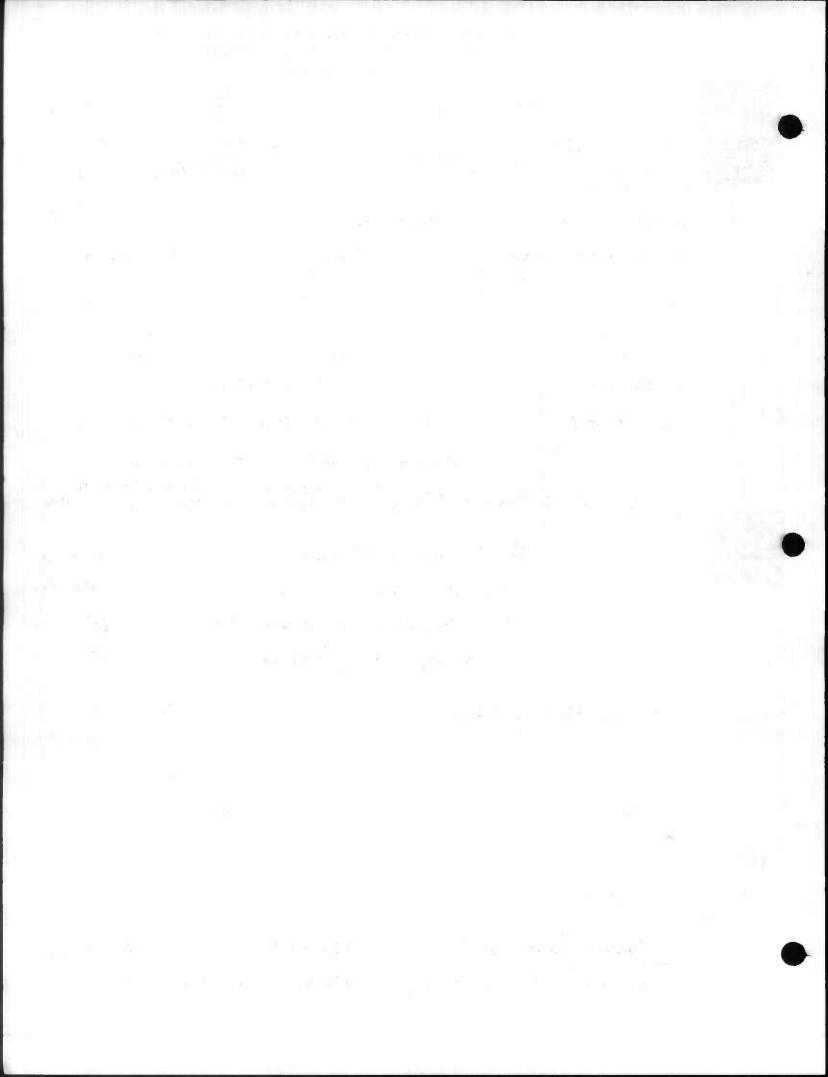
State

Registrar

31. Dete filed (Month, Day, Year)
DEC 28

1999

32. Registrer's Signeture



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

						Cert	ificate	of Death	R	g. No.	3 1	+1995		
	Bloodeles	1. Decedent's Name	e (First, Middle, Las	1)					2. Dete of Deat Month	h Dey_	Year	3. Time of Death		
	Physician / Medical			P	hilli	p Jose	ph Dar	nna	Decemb	er 27,	1999	12:30 pm		
N	Examiner	4a Facility Name (//							Location of Death	4c. County				
			ddin Driv					Laurel		Howa				
	Funeral Director	5. Social Security Number 215-38-2541 7. Age (In yrs. lest birthday) 58 Yrs. 1 Under 1 Year If Under 24 Hrs. Months Bays Hours Min. 8. Dete of Birth (Month, Dey, Ye Sep 16,										ace (Stete or Foreign try) rland		
pu	3	Usual Residence of 10e. State	Decedent 10b. County		10c City	Town or Loca	ation				10	0d. Inside City Limits		
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th with th	23a or 28a-f e unt be northed ral Director	10e. Street and Nur 7990 Ala	^{nber} addin Driv	<i>7</i> e			10f. Zip Co 2072			0g. Citizen of V USA	Vhat Count	iry?		
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Meryland	naturel', or items 23a or 28a-1 show solidal Examines must be notified at letted by Funeral Director	11. Meritel Status 1 □ Never Marri 3 □ Widowed	ed 2 💢 Married 4 🗆 Divorced	12. Was Decedent Armed Forces? 1 [XYes 2 ☐ If Yes, Give Year or Dates:			as Deceden Yes, specify ☐ Yes 20	t of Hispanic Origin? (: Cuban, Mexican, Puei (No Specify:	Specify Yes or No- to Rican, etc.)		ea - America ck, White, e White	etc.		
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Balt Permit.	Department Important: If any Injury o once.	21. Signature of Fu	neral Segrica Licens	100		22. Do	Neme and A	Address of Facility on Funeral	Home, P.	Α.				
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ords	sate hes been signe page 2 should be c Completed by								24a. Was a perfor		eva cor	are autopsy findings aileble prior to mpletion of cause		
Rec	hes Pe 2									-2-		death?		
= -	certificate he rector, page	05 11/							1 U Y	0	11	Yes 2 No		
of Vital		25. Was case reference examiner?		Hospital:	001		20 004	Other: 4 Nursing	eath (Check only or	enca 6 □Oth	nas (Canaih	id.		
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Out	After funer	1 Matural 2 Accident	5 Pending investigation	(Month, De	y Yeer)	Injury	м	Work? 1 ☐ Yes 2 ☐ No						
Division	is effected death. al Director: Affect ed in by the funeral Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)					28f. Location (Street end Number or Rural Route Number, City or Town, State)					
Hospital	within 24 hours effect de To the Funeral Directo completely filled in by the Medical Certific	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	Inar: On the basis of	f examinati	viedge, death ion and/or inve	occurred at estigation, in	the time, date and place my opinion, death occ	ea, and due to the courred at the time, of	ause(s) and m late end placa,	anner as st and due to	ated. the cause(s)		
eth o	Med Med	29b. Signeture/and	title of certifier (and menner st	(/	1	29c. l	icense number	1 2	9d. Date signe	d (Month,	Day, Year)		
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5	Ivet	Ju. Name and addr	ess of person who d	completed cause of	meth) maec	∠da) (Type, P	LIL I	38509 Datuxent f	1/m. C.1.	unhun	mi	21044		
	State	31. Date filed (Mon	th, Dey, Year)	32. Regist	er's Signat	ure LI	TYK	TIMENI	1190010	MOIN	1110			
	State			999	Russer	v 14		2011						

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death DEC. **Physician** DWAYNE 1:08 PM DRIVER CARTER /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street end number) 4c. County of Death Examiner GEORGES HOSPITAL CENTER CHEVERLY PRINCE GEORGES If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey. Hours Min. Dey. FC. 18. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** 1MM 2□F Yrs Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. Counts 10d. Inside City Limits show 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at Yes 2 No MARYAND PRINCE GEORGES CAPITAL HEIGHTS Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 401 DATELEAF AVENUE 20743 U.J.A. Funeral 12. Was Decedent Ever in U,S Armed Forces? Race - American Indien, Black, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status pernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important if Item 27 is marked other than "natural", or ite any injury or other traumate event, the Mental Examine. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Merried Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK Aq 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) INFANT INFANT 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) CLARENCE HENDRICK ALYCE DENISE DRIVER 19b. Melling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Relationship (Type, Print) ARINCE GEORGES HOSPITAL CENTER 3001 HOSPITAL ARIUE, CHEVERLY MD 20785 Saltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Property April 2 10 10 10 of Funeral Service Lip 22. Name end Address of Facility Chi fuller the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cause of heart feilure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Physician /Medical Immediate Cause (Finel disease or condition resulting In death) Examiner SEVERE PREMATURIT Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest Due to (or as e consequença of) Bud Box 68760 physician 2 Due to (or as e consequence of): # attending 85 signed by the a d be detached if P.O. Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings evailable prior to Completed 24a. Wes an autopsy completion of cause of death? 1 ☐ Yes 2 PNo 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Wes case referred to medical axaminer? å 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpetient 3 DOA 芸 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? After 1 Netural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director 3 ☐ Suicide 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) ather a 4 Homicide 24 hours a To the Hospital with 24 hours a To the Funeral completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. | Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. Medical 29e. Certifier 29b. Signeture and title of centiller 29c. License number 29d. Dete signed (Month, Dev. Year)

State Registrar 30. Name and address of person who completed cabs

DEC 3 0 1999

31. Date filed (Month, Dey, Year)

DHMH 16 Rev 6/95

ORIGINAL

HOSPITAL

DE

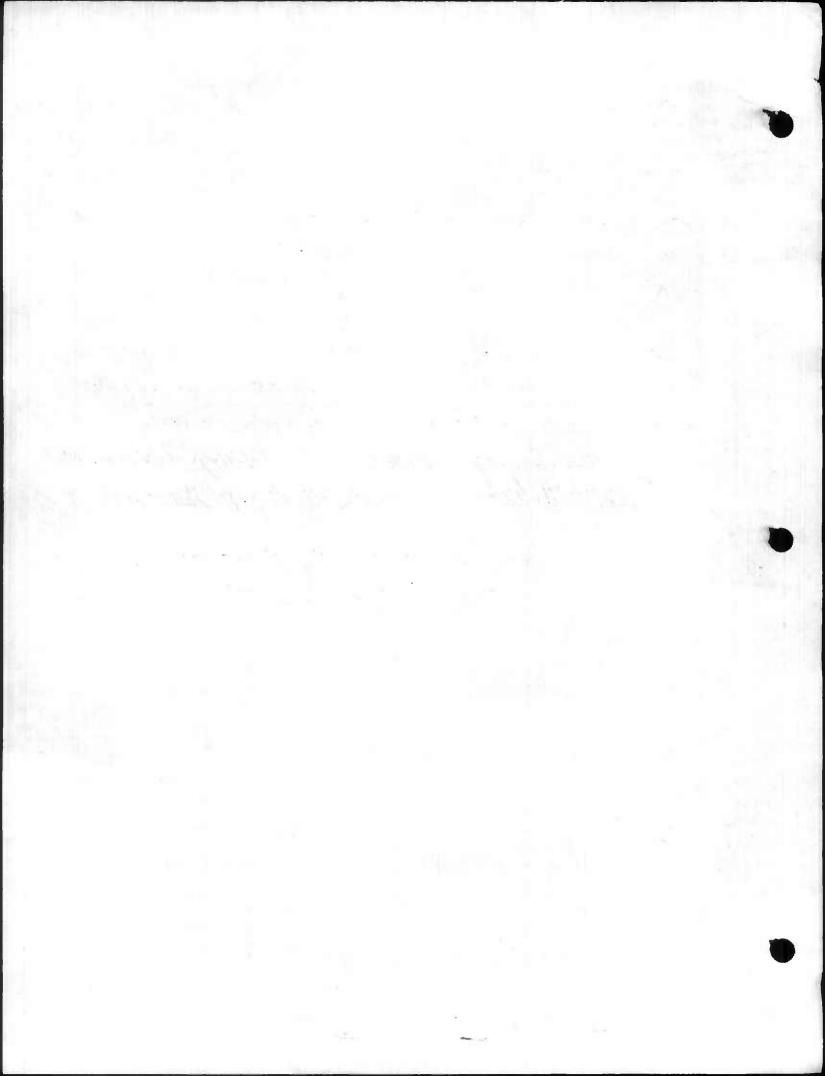
CHEVERLY

of death (Item 23a) (Type, Print)

3001

MD

32. Registrar's Signeture



Please Type or Print In Black indelible Ink. Assure All Copies Are Legible.

Certificate of Death Reg. No.	99	419	9
tate of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.	DO	1 10	

			Certificate (of Death	Reg. No	99	41991
Obvertaion	1. Decedent's Name (First, Middle,	.ast)			2. Date of Death Month De	y Year	3. Time of Death
Physician /Medical	Bernard Neal	Exline			December 2	2, 1999	8:25 P.M.
Examiner	4a Facility Name (If not institution, g			4b. City, Town, or Local	ation of Death 40	. County of Death	
	Washington Co		Milada 1 W	Hagersto		ashingto	
neral		Sex 7. Age (In 1 N 2 □ F	yrs. last birthday) If Under 1 Y Months De	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, Year,	9. Birth	nplace (State or Foreign untry)
ctor	212-38-8791 Usual Residence of Decedent	^	58 Yrs.		Sept.22,19	41 Wes	t Virginia
by Funeral Director	10a. State 10b. County	100	City, Town or Location				10d. Inside City Limits
to	Maryland Was	hington	Sharpsbu	ra			1 X Yes 2 □ No
Director	10e. Street and Number		10f. Zip Co		10g. Ci	tizen of What Co	untry?
	143 East High	Street	2	1782		USA	
Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	If Yes specify (of Hispanic Origin? (Spec Cuban, Mexican, Puerto R	cify Yes or No-	14. Race - Amer Black, White	
F	1 Never Married 2 Married		1960- 1□ Yes 2₩				
d by	3 ☐ Widowed 4 🏋 Divorced	Year or Dates:	1964 ^			WILL	ite
lete	15. Decedent's (Specify only highest)		16a. Decedent's Usual Or (Give kind of work de life. DO NOT use re	one during most of working	g 16b. F	(ind of Business/I	ndustry
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Self Empl			Trucki	ng
	17. Father's Name (First, Middle, La	st)	Sett Empt		(First, Middle, Maidei		ng ·
To Be	Authur Dequoy	Exline		Wills	Larue Ca	nfield	
-	19a. Informant's Name/Relationship		19b. Mailing Address (St	reet and Number or Rural			ip Code)
	Michael Exline-	Son		ada Court Ha			
	20a. Method of Disposition		Ob. Placa of Disposition (Name of cametery, crematory or other	of		ocation - City or	
	1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	Mt. View Cemete		2-28-99 Sh	arpsburo	,Maryland
4	21. Signature, of Funeral Service Lig			ddress of Facility Funeral Home		o. pos a. g	, not y rome
once	D ////	m VI		runeral Home port,Marylan		.0. Box	348
a a a a a a a a a a a a a a a a a a a	23a. Part 1. Enter the disease, or co shock, or hear failure. List on Immediate Cause (Final disease or condition resulting in death)	Subdiaple		scen with	1	F pt	friterval Between Onset and Death
min		& kuft 4	to (or as a consequence of):				
Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that injusted exercises)	Due	to (or as a consequence oi).				
dical	frief wiffleren exerif?	c. Due	to (or as a consequence of):				
led	resulting in death) Last	.500					
2		d				1	
Physician/Me	Part It. Other significant conditions	contributing to death but no	t resulting in the underlying caus	e given in Part I.	23b. Did tobacc	o use contribute	to the cause of death?
					1 Yes	2□No 3□Pi	obably 4 Unknown
Completed by				24a. Was en auto performed?	Were autopsy findings available prior to completion of cause		
dmi					A.		of death?
e Co	25 Was seen referred to madical			00 010 10		2□ No	Yas 2 No
m	25. Wes case referred to medical examiner?	Hospital:	OF ED/Outpotient OF DOA	Other:		6 DOHA- /6	nihe)
To To	1 Yes 2 No 27. Menner of Death	28a. Dete of Injury	28b. Time of 28c.	4 Nursing Hom	ne 5 Residenca 8d. Describe how inju		ony)
tion	1 Natural 5 Pending 2 Accident investigat	(Month, Day Yea	ar) Injury M	Work? 1 ☐ Yes 2 ☐ No			
Ca	3 ☐ Suicide 6 ☐ Could no	be 28e. Placa of fnjury -	At home, farm, street, factory, of		8f. Location (Street 8		ıral Route Number,
-		building, etc. (S)	pecify)		City or Town, Sta	10/	
ertif	4 Homicide	Danishing, etc. (e)	,				
sai Certification:	29a. Certifier 1 Certifying	Physician: To the best of my	rknowledge, death occurred at ti				
completely filled in by the funeral	29a. Certifier 1 Certifying	Physician: To the best of my					

*a 111 P

111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

State Registrar

DEC 2 7 1999

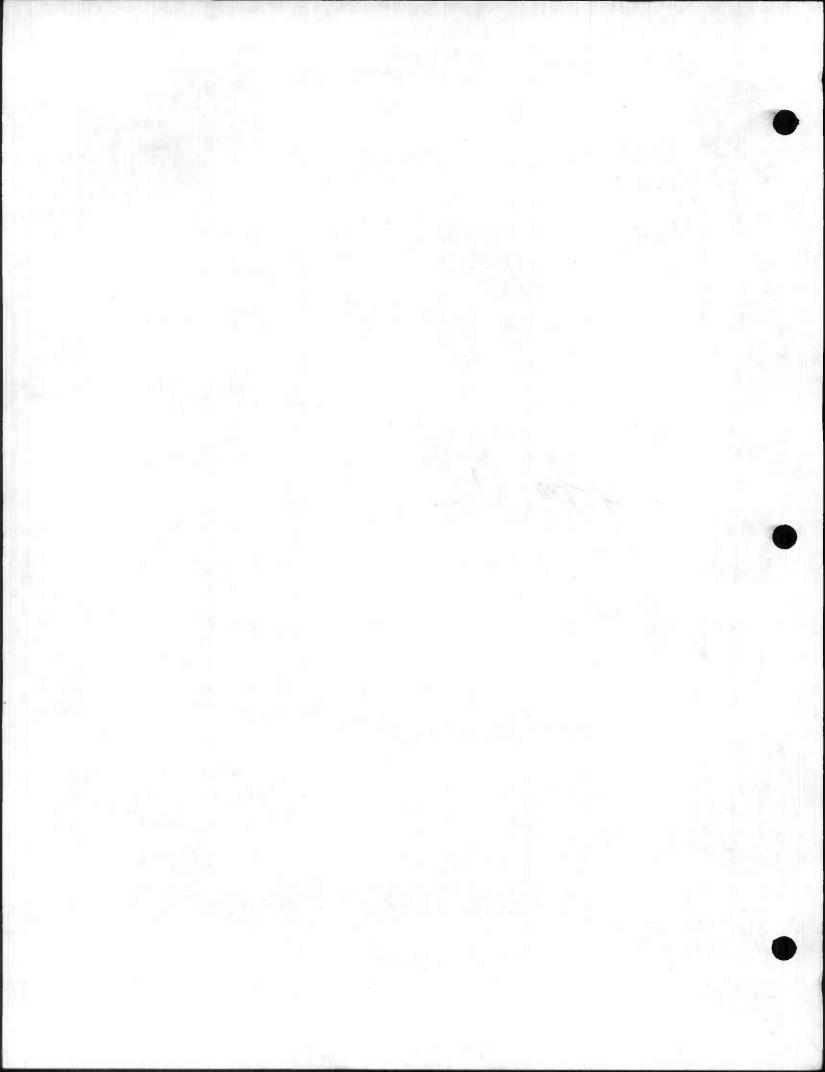
30. Name and address of person who completed cause

32. Registrar's Signature

in (Item 23a) (Type, Print)

O.C.M.E.

December 24, 1999



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's	Name (First, Mid	kile, Last)								2. Data of D			3. Tima of Dea
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dical		ma (If not instituti			nber)				4b. City, Town	n, or Loc		- Anna -	ounty of De	
miner														
		ngton Co					. Million	der 1 Yaar	Hager:				hingt	
ral	5. Social Secu	rity Number	6. Sex	M 2ØF	7. Age (In yr.	s. last birthday)	Month		Hours	Min.	8. Date of Bi (Month, D	irth ay, Year)	9. 8	Birthplace (Stata or Fo. Country)
or		9-2745		-XY	85	Yrs.					June 9	1914		Maryland
		ce of Decedent												
	10a. State	10b. Coun	ity		10c. C	City, Town or Lo	ocation							10d. Inside City Li
Director	Mary1a	and Was	hing	ton		Нада	ersto	15/T1						1 Yas 2
ě	10e. Street and		III	COIL		nage		Zip Code				10g. Citizer	n of What	Country?
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Funerel	11. Marital Sta	190		12. Was Dece Armed For	rces?	0,5. 13.	If Yes, sp	pecify Cuba	lispanic Origi an, Mexican,	Puarto F	Rican, atc.)	0- 14.	Black, W	merican Indian, hita, atc.
		Married 2 ☐ Ma		1 ☐ Yes If Yes, Give	2.0 No		1□ Yas	2X No	Specify:			Sr	pecify:	
by	3 V Widow	red 4 Divorce	ed	Year or Da	ates:								, ooy.	White
Completed		15. Decade Specify only high				16a. Dece	dent's Us	sual Occup	ation during most o	of work in	20	16b. Kind	of Busines	ss/Industry
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E	12	Occirculty (0-12)	'	0	401 34)	5	Secre	etary				La	undry	7
C	17. Father's No	ame (First, Middle	e, Last)						18. Mother's	s Nama	(First, Middle	e, Maiden Su		
Be		am Statt		OLIM OF								th Sch		ckt
2														
	19a, Informan	t's Name/Relation	nship (Ty)	pe, Print)		19b. Meili	ing Addre	ess (Street	and Number	or Rura	l Routa Numi	ber, City or T	own, State	a, Zip Code)
	_Judy	Ann Resh	1 -	Daugh	ter	1731	13 Or	ntari	o Driv	e H	Hagerst	town,	Md. 2	21740
	20a. Method of	•				Place of Dispo	osition (A	Vama of	ne)	-	Data	20c. Loca	tion - City	or Town, Stata
		2 Cremation		emoval from S						11.0	/20/00	II		www. Massell.
					K	est Hav								wn, Maryla
S C C	21. Signature	of Funeral Service	e License	22		/ 2			ss of Facility			Funera		
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Fields, Hinnie Pauline

NAME: FIELDS, MINNIE PAULINE

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DOS:

H215881

Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Deta of Deeth Month LTLLY FYLE PEARL 0335 2 07 4b. City, Town, or Location of Deeth 4a. Facility Neme (If not institution, give street and number) 4c. County of Death Dorchester Chesapeake Woods Center Cambridge If Undar 1 Year If Undar 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth Month, Day, Year) Dec. 22 1912 9. Birthplace (Stata or Foraign Country) West Virginia Months 10 M 20 F 232-54-0686 86 Yrs Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Cambridge TE Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21613 U.S.A. 525 Glenburn Ave. 12. Was Decedent Evar in U.S. Armed Forcas? 14. Race - American Indien, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 1 Nevar Married 2 Married 1 ☐ Yes Z☐ No If Yas, Give 1□ Yes 22 No Specify white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) restaurateur restaurant 8 18. Mothar's Neme (First, Middle, Maiden Sumama) 17. Fether's Neme (First, Middle, Last) Ashlev Alice Adkins Albert 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) James A. Martin - son P.O. Box 434, Bridgeville, DE 19933 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete TZ Burial 2 Cremetion 3 Ramovel from Stete 4 Donation 5 Other (Specify) Walnut Grove Cemetery 12-11-99 Strangecreek, W VA 22. Nema and Addrass of Fecility Thomas Funeral Home PA 21. Signeture of Funeral Service Licenses 700 Locust St. Cambridge, MD 21613 mouth R Pert1. Enter the disease, or complications that caused the dauth. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Approximeta nterval Between Immediete Cause (Finel disaesa or condition resulting in deeth) Sepsis 14 days Due to (or es e consequence of): Sequentielly list conditions, if eny, leading to Immediate causa. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es a consequance of). Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the cause of death? 1 Yee 2 do 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 28No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 28. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funerai

þ

Completed

Funeral

Director

Itam 27 is marked other than "natural", or itams 23s or 28s-1 show other traumatic evant, the Medical Examinar must be notified at

permit. Pagas 1 and 2 should be filed within 72 hours after to operture of Hastin and Mental Hygiena. Important: if item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Exempted

Saltimore, Maryland 21215-0020

physician and s the burial-transit USB BS been signed by the attar this cartificate has Hospital or Attending Physician: 24 hours after death.
Funerei Director: Atter this cartifica To the Hospital or Attending Phy within 24 hours after death. To the Funerel Director: After this completely filled in by the funaral (

P.O. Box 68760,

Division of Vital Records.

Physician/Medicai þ Completed Be

Examiner

2

27. Menner of Death Certification:

Medicai

1 Natural 2 Accident 3 Suiclde

1 ☐ Yes 2 ☐ 4No

4 Homicide

29b. Signature end title of certifier

29a. Cartifier

5 Pending Invastigation 6 Could not be determined

28a. Dete of Injury (Month, Day Year)

1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Other: 4 Lursing Homa 5 Residence 8 Other (Specify) 28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

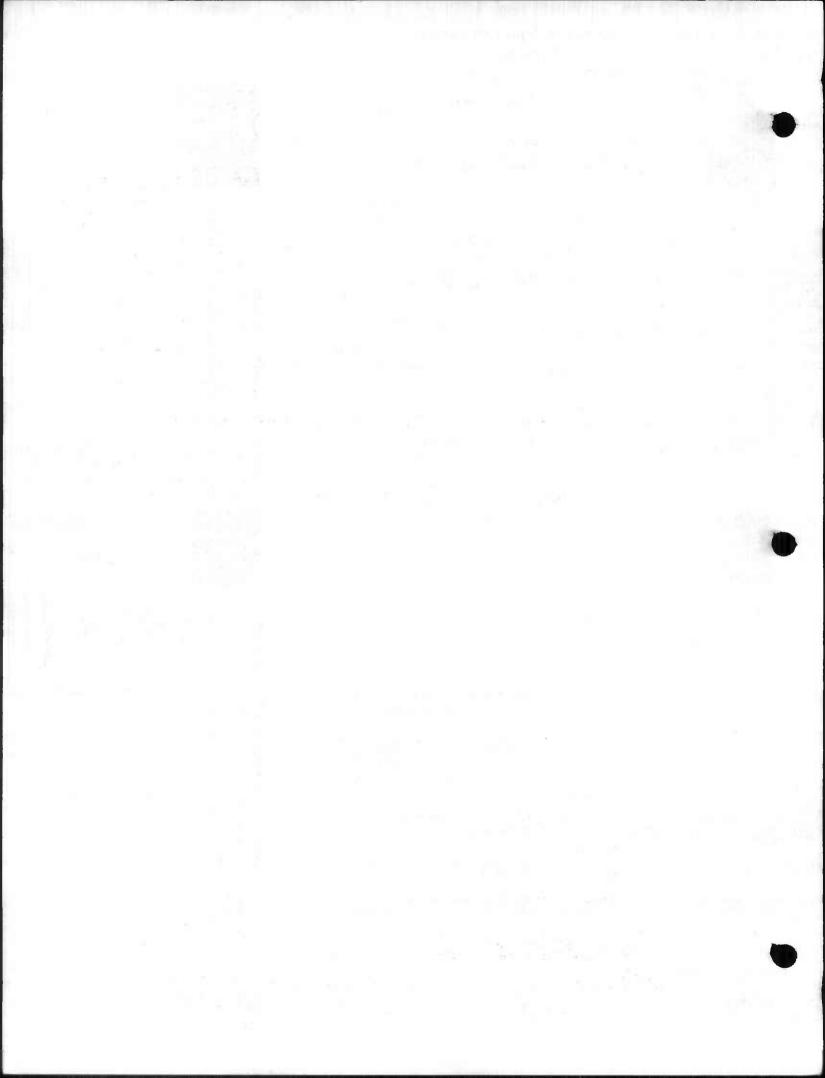
Decartifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

Madical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Data signed (Month, Day, Year)

ne and duress of person who completed cause of deeth (Item 23a) (Type, Print)

302 Celling Ne Hurlock MD 71643 Mich 32. Registrar's Signature

State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

42000 2. Date of Death 3. Time of Death 1 Decedent's Nama (First Middle Last) **Physician** Month Dec. 24ay Mary Edna Fleming 2:30 AM /Medical 4s Fecility Neme (If not Institution, give street end number) Church Hill MD 4b. City, Town, or Location of Death 4c. County of Death Examiner 222 Walnut St. Schuyler Nursing Home, Church Hill Queen Anne's Co. if Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Undar 1 Yaar Months Days 5. Social Security Number Birthplace (Steta or Foraign Country) 6. Sex 7. Aga (In yrs. last birthdey) 1□ M 2□ F 101 Director 213-22-6230 Usual Rasidanca of Decedant 09-18-1898 with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director Queen Anne's 222 Walnut St., Church Hill MD 21623 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? U.S.A. Funeral 222 Walnut St. deeth 12. Wes Decedant Evar in U,S. Armad Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) 14 Race - American Indian 11. Meritel Stetus Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Heelith and Mental Hygiens. Important: If item 27 is marked other than "natural, or ite eny Injury or other traumatic event, the Medical Examine 1 Nevar Marriad 2 Married 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Datas: white Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation
(Give kind of work dona during most of working life. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16h Kind of Business/Industry Collega (1-4or 5+) Elamantary/Secondary (0-12) education 12 principal of schools 18. Mothar's Name (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Kate Thompson Wilbur P. Fleming 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Typa, Print) Robert Barton P.O. Box 357 Queen Anne, Maryland 21157 3altimore, 20b. Place of Disposition (Nama of camatary, cramatory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 A Cramation 3 ☐ Removal from State 106 Shamrock Rd. Chesapeake Cremation Cen. 12-26-99 4 ☐ Donation 5 ☐ Other (Specify) Chester, MD 21619 21. Signatura of Funaral Sarvice Licensee 22. Nama and Address of Fecility any Ir Fellows, Helfenbein & newnam Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac of respiratory arrast.

21619 numas Interval Batween Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in daath) & CONGESTIVE HEART FAILURE 3 WK. Examiner > /oyr. Examiner ATHEROSCUEPUTIC CARDIOVASCUAR DISEASE requires that the death certificate be executed physician end the burial-trans Sequentially list conditions, if any, leading to immediata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants resulting in daath) Last Due to (or as a consequanca of): Box 68760. Physician/Medical Dua to (or as a consequence of): JSa Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ADVANCED AGE Division of Vital Records, þ 24b. Wara autopsy findings availabla prior to completion of causa ot death? 24e. Wes en autopsy performed? Completed SENILE DEMENTIA certificata hes 1 Yas No Hospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certifical 25. Was casa refarred to medical examinar? Be 26. Place of Death (Check only ona) CARE HOME Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Data of Injury (Month, Day Year) funarai 28d. Dascribe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 5 Panding Invastigation 10 Natural 1 Yas 2 No 2 Accidant 6 Could not be datarmined 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 | Homleida Certifying Phyaician: To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated.

— Medical Examiner: On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data end place, end dua to tha causa(s) and mannar stated. 29a. Certifier edical (Check only one) within 2 To the F 29b. Signatura end titla of certifiar 29c. Licansa number 29d. Date signed (Month, Day, Year) 9 12 D41587 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Helen Noble 122 Speer Road Chestertown, Maryland 21620 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

B. Sparker

State Registrar

DEC

